		1	For State Registrar	State of	Marylan		rtment of I	Health and Death		giene Reg. No 7 1 1 5	20001
	Physicia	_	1. Decedent's Name (First, Middle		RICK I	HILL			2. Date of Dea Month MAY	Day Year 27 2005	3. Time of Death
	/Medic	al _	11 RONE FIAT				4b. City, Town,	or Location of Deat	1	4c. County of Deat	
	Examin	er	PRINCE GEORGE'			ER	CHEVE	RLY		PRINCE GE	ORGE'S
	uneral irector		5. Social Security Number 578-84-8537		7. Age (In yrs. 47		If Under 1 Year Months Days		(Month, Day	9. Bird (C) 18 1958 WAS	thplace (State or Foreign ountry) SHINGTON, DC
/land	Mo!	. I−	Usual Residence of Decedent 10a. State 10b. County		10c. Cir	ty, Town or Lo	cation				10d. Inside City Limits 1X☐ Yes 2☐ No
Mar	a-f sh	ctor	MD PRINCE	E GEORGE'S	.]	FORESTV					
ith the	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	ountry?
ath w	8 23a	rai	7145 DONNELL PI		edent Ever in U	18 13 1	20747	Hispanic Origin? (Specify Yes or No-	U.S.A.	erican Indian,
within 72 hours after death with the Maryland	Department of neath and workers regions in the 23a or 28a-f show more contracts. If the 27 is marked other than "natural", or items 27 is marked other than "natural", or items 21 is marked other than any injury or other traumatic event, the Medical Evantrat has been called at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	ried 1 XYes	rces? 2 ∐ No /e	1	f Yes, specify Cul 1 ☐ Yes 2🎇 No	oan, Mexican, Puer	to Rican, etc.)	Black, Whit	te, etc. BLACK
72 hour	"natural edicul Ex	Completed	15. Deceden (Specify only highe	it's Education st grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retir	during most of wo	nrking	16b. Kind of Business	/Industry
withir	than	dwo	Elementary/Secondary (0-12)	College (1	-4or 5+)	SPEC	IAL POLI	CE		GOVERNMEN	T
beliled	other /ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	•	Maiden Surname)	
uld be	rked rtic e	ToE	S. T. HILL						P. SEAY		
2 sho	is me		19a. Informant's Name/Relations							er, City or Town, State, TVILLE, MAI	
and	m 27 her tr		BRENDA HILL/WI 20a. Method of Disposition	LFE	20b.	Place of Dispo	sition (Name of		Date Date	20c. Location - City or	
1995	or of		1 Surial 2 Cremation		State	cemetery, crei	matory or other pi		2/05	CLINTON, MA	RYLAND
it. Pa	rtant	1	'4 □ Donation 5 □ Other (S		RE			ETERY 6/3		KINS FUNERA	
perm	any in		A Colon		6		7474 LAN	DOVER ROA	D LANDOV	VER, MARYLA	ND 20785
/N Ex	ysician Medical aminer	iner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, rr any, reading to immediate cause. Enter Underlying Cause (Disease or injury	a Co	NGES (or as a conse	equence of):		ant to	icure		Onset and Death
Attending Physician: The law requires that the death certificate be executed	ing physician and e as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	d	(or as a conse					22d Date of de	pliver/
the death ce	by the attending phi tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	Itcome of pregr birth 2 Per nant at time of nown	tal death 3[⊒Ectopic pregnar □ Other (specify)	ncy		23d. Date of de Month	Day Year
quires that	been signed b should be deta	by	Part II. Other significant condit		leath but not re		OLS EAS			tobacco use contribute Yes 2 No 3 F	to the cause of death? Probably 4
The law re	2 5	Completed	Dianse1	iss Mé	W170	/ζ			24a. Was auto perfe 1 \(\text{Yes}		
ian:	is certificate ha director, page	Be	25. Was case referred to medical examiner?						eath (Check only		
ling Physic	n. After this ce funeral dire	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date	Inpatient 2 of Injury onth, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. In			idence 6 Other (Sp how injury occurred	pecify)
al or Attend	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could	d not be 28e. Place	e of Injury - At ding, etc. (Spec	home, farm, si	treet, factory, office		28f. Location City or To	(Street and Number or I own, State)	Rural Route Number,
To the Hospital	24 hour: 9 Funera stely fills	edical C	29a. Certifier (Check only one) Certify Certify 2 Medica	y f⊈xaminer: On the l	ne best of my ki basis of examin	nowledge, dea nation and/or i	ith occurred at the nvestigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time	a cause(s) and manner , date and place, and d	as stated. ue to the cause(s)
	ithin o the omple	Mec	29b. Signature and title of cert	H10 -			29c. Lice	ense number		29d. Date signed (Mo.	
o the				1/1/	CW		2	-000-		1-1-1	h pm
To the	× F 0		• • •	ym/	140			53885		6-16	25
To the	4		30. Name and address of perso	n who completed cau				0	WALDER	6-1-0 ef, MD &	20602

			1- State of Maryland / Dep	artment of Health and Natificate of Death		giene 005	20002	
			Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath	3. Time of Death	
	Physici /Medi		Kenneth Matthew Haensler		May 29.	Day Year 2005	12-10	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea		
			422 South Blvd.	Salisbury		Wicomic	0	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bi	rthplace (State or Foreign country)	
	Director		213–26–9965 75		2/10/19			
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
	Aaryl sho	٥					1 XYes 2 No	
	the A	ect	Maryland Wicomico Salisbu	10f. Zip Code	1.	10g. Citizen of What C		
	with	2	422 South Blvd.				ountry	
	eath	Funeral Director		21801 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Am	erican Indian	
10	fter d	F	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi		
036	urs a	þ	3 Xwidowed 4 □ Divorced If Yes, Give Year or Dates: Army	1 ☐ Yes 2 ☑ No Specify:		Specify:	white	
21215-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-1 show dical Examinat must be profilled at	Completed	15. Decedent's Education 16a, Dece	dent's Usual Occupation		16b. Kind of Business	s/Industry	
218	thin 7	ple	Flynoria (Caracter (O.10)	kind of work done during most of work DO NOT use retired)	ang			
21	gien gien erth	50	12 4 CIV	il Engineer		Engineeri	ng	
P	al Hy al Hy f oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Sumame)		
la	Ment Ment Arked	10	Matthew Haensler	Meta Pr	aeger			
Maryland	2 shc and ls ma		7 7 30 7 /	ng Address (Street and Number or Rul			Zip Code)	
	and ealth n 27			Camden Ave., Sali	sbury, M	D 21801		
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iteme 23s or 28s-f show appringury or other traumatic event, Ite Medical Examinal most be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City or	Town, State	
Ē	Peg ment ant: ury c		`4 Donation 5 Other (Specify) Salisbury	Crematory 6/1/	05	Salisbury,	MD	
Salt	permit. Depart Import eny inj		21. Signature of Funeral Service Licensee	2. Name and Address of Facility IOI loway Funeral H	omo Drof	Forgional 7	\	
_	20 E E G		23a. Part1. Enter the disease, or complications that caused the death. Do not en	501 Snow Hill Rd.	Salish	rv. MD 218	SSOCIALION 204	
*			22a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arr	est.	Interval Between	
	Physician		minediate Cause (Final disease or condition De went a	(Alzheimer's)			Onset and Death	
*	/Medical		Due to (or as a consequence of):					
	Examiner		Sequentially list conditions. b					
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	and and I-trans	cam	that initialed events		 			
30,	be executed ilcian and burial-transit	<u> </u>	Due to (or as a consequence of):					
8760,	icate be ex physician s the buria	dicai	d					
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Mec	IF FEMALE:	·				
Вох	ath c	Physician/Me		Ectopic pregnancy		23d. Date of de Month	livery Day Year	
0	the a	sic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day	
0	that the died by the detached		Part II. Other significant conditions contributing to death but not resulting in the u		220 Did tot	bacco use contribute to	a the course of disable?	
Records,	signe d be (ğ	Clarair Obsta of 2	Acception of the control of the cont	1,00		robably 4 Dunknown	
Ö	w requir been si should	etec	Marie Commence Marie Tour	insure;		2 2 110 3 1	- Onknown	
Sec.	has by	Completed	Hypertensian, Atrial Fibrilla	etion	24a. Was a autops	y prior to	utopsy findings available comptetion of cause of	
A F	: Thi	Ö			perform 1 ☐ Yes 2	ned? death?	2 □ No	
Vita	yeicien: The Is certificate hadirector, page	Be	25. Was case referred to medical examiner?	26. Place of Deat				
of Vital	Physician: this certificatal director, I	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier				cify)	
		lo I	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time o	Work?	28d. Describe ho	w injury occurred		
Sic	ttendi death. ctor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No				
Division	after after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, lactory, office	City or Town	reet and Number or Ri n, State)	ural Route Number,	
_	pital		29a, Certifier 1 Certifying Physician: To the best of my knowledge deat					
	Hos 24 ho Fun stely	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat of the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Mec	29b. Signature and title of certifier	29c. License number	2:	9d. Date signed (Mont	h, Dav. Year)	
	H 3 F 8		A DICE		10	There	2005	
	1/2		y my ician	H57291 (m	")	June 1	1 6003	
	100		30. Name and address of person who completed cause of death (Item 23a) (Type. T. C. Catronica, D.O., 1876 Sweet Ber	Drive, Suite 101	Selishu	m. 4-70 7.1	804	
	Sta	te.	31. Date liled (Month, Park Mean 9 2000 32. Figistrar's Signature		7	11-00	- 1	
€	Registr		31. Date liled (Month, Pry Near) 2 2005 32. F Sistrar's Signature	code				

		1 - For State Of Registrar	Maryland / De	Certificate of			gierie Rag. No.	
Physic /Medi		Decedent's Name (First, Middle, Last) John Gary Jacks	on, Jr.			2. Date of De Month May	_ / / / /	3. Time of Death 05 11:40 AM
Exami		4a. Facility Name (If not institution, give street and numb	er)		r Location of Death		4c. County of E	
Funeral Director	1	Continuum Care 5. Social Security Number 218-32-4906 6. Sex ★□ M 2□ F	Age (In yrs. last birtho	(ay) If Under 1 Year Months Days	ykesville If Under 24 Hrs. Hours Min.	8. Date of Birt		rroll Birthplace (State or Foreign Country) laryland
_		Usual Residence of Decedent					- 7 3 1 2 2 1 1	- Tana
arylan show	_	10a. State 10b. County	10c. City, Town o					10d. Inside City Limits 1 X Yes 2 □ No
the M 28a-f	Director	Maryland Carroll 10e. Street and Number	West	10f. Zip Code			10g. Citizen of Wha	
3a or		88 W. Main St. Apt A1		21157			USA	Country :
death	Funerai	11 Marital Status 12. Was Deced	ent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No		American Indian,
urs after ai', or ite Examine	b	Armed Force 1 Never Married 2 Married In Yes 2 3 Widowed 4 Divorced Year or Date	TNO	1 ☐ Yes 🎾 No	Specify:	Hican, etc.)	Specify:	Vhite, etc. Black
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. Its Medical Exportment traumatic event. Its Medical Exportment	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(6	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	during most of work	king	16b. Kind of Busin	ess/Industry
ygien ygien yer th	Con	12		ntenance	7.7.		College	2
Ibe fil ntal H ed off	Be	17. Father's Name (First, Middle, Last) John Gary Jackson, Sr.			18. Mother's Nam		Maiden Sumame)	
thould Mei	은	19a. Informant's Name/Relationship (Type, Print)	19b M	lailing Address (Street			ar City or Town Sta	te Zin Codel
nd 2 s lith an 27 is r trau		Anthony D. Jackson/son		.0. Box 251			Md. 21791	
s 1 and of Health item 27 other tr	-	20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place	1	Date	20c. Location - City	
Pages nent of h ant: if ite		1 ☐ Burial 2 XCremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	ate All Cour	nty Cremati	on May	21,2005	Sykesvil	le, Md.
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: If Item 27 is marked other than any injury or other traumatic event. It M. Once.		21. Signature of Fuheral Sinvice Licensey		22. Name and Addre			Funeral H	
Physician		23a. Part . Enter the dilease, or complications that ca shock, or heart failure. List only one cause on ear Immediate Cause (Final	ed the death. Do not					Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death) a. Y Due to (o	as a consequence of)	tic Co	ncer	96	Co 107	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of)	· W				
icate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events c.	5 · N · D					
be exician governal	i Ey	Due to (o	as a consequence of)	•				
tificate ng physi as the	edicai	d	- 1 - 1 - 1	•				
ath cer	hysician/Me	in the past 12 months?	ome of pregnancy h 2 Fetal death nt at time of death m	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of Month	f delivery Day Year
that the dened by the a	0	Part II. Other significant conditions contributing to dea	th but not resulting in the	ne underlying cause giv	ren in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
w requires that been signed should be def	ted by					10		Probably 4 Unknown
: The law cate has b	Completed						osy prior deat	e autopsy findings available to completion of cause of h? Yes 2 \Bo
sician certif rector	o Be	25. Was case referred to medical examiner? Hospital:		Oth	26. Place of Dear			
Phy or this oral di	-	27. Mann Death 28a. Date of	nationt 2 ER/Outp	ne of 28c. Injur	v at		dence 6 Other (Specify)
nding th. r: Afte e func	atior	1 Natural 5 Pending (Month 2 Accident investigation	Day Year) Inju	ıry Wor	k? Yes 2 □ No		, ,	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined 28e. Place of building	f Injury - At home, farm g, etc. <i>(Specify)</i>	street, factory, office		28f. Location (: City or Tox		r Rural Route Number,
e Hospit 24 hours e Funera letely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner	is of examination and/	death occurred at the tir or investigation, in my o	me, date and place, ppinion, death occur	and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifion	1\1	29c. Licens			29d. Date signed (N	
154		XY16/CCV	our 1.	D-0	0054	218	05-2	0-2005
MJ		30. Name and address of person who completed cause DR Raman B Kan	of death (Item 23a) (Ty	pe, Print) 1 Malcal	y Drive	. We	ofminte	0-2005 IMD 21157
	ate		grar's Signature			-		

			1 - State of Maryland / Depa	rtment of Health and M tificate of Death	ental Hygier	611115	20004
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joseph Daniel Jeffrey			Day Year 2005	3. Time of Death 18:30
	Examir	er	4a. Facility Name (If not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death Bethesda			omery
Ì	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Cour	place (State or Foreign htry) Ler, CO
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or Apher traumatic event, the Medical Examinar must be notified at any Injury or Apher traumatic event, the Medical Examinar must be notified at another.	Director	10a. State 10b. County 10c. City, Town or Loc MD Montgomery North Be 10e. Street and Number 10500 Rockville Pike #1002			Citizen of What Cour	0d. Inside City Limits 1 √ Yes 2 □ No ntry?
9800	nours after death urel', or Items 2:	d by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto f ☐ Yes 2♥ No Specify:		14. Race - Americ Black, White,	
21215-0036	d within 72 h giene. er than "natu	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of workin O NOT use retired) ney	ng	Kind of Business/In	dustry
Maryland	outd be file Mental Hy tarked oth	To Be (17. Father's Name (First, Middle, Last) William M. Jeffrey	Milda	(First, Middle, Maidered Saunder	ers	
	ges 1 and 2 sh t of Health and if Item 27 Is m			r, CO 802	er, City or Town, State, Zip Code) 80211 20c. Location - City or Town, State		
Baltimore,	permit. Par Departmen Importent: any Injury			2, 2005 eph Gawler , NW WDC 2			
	Prysician /Medical Examiner		23a. Part1. Enter the disease, or complications that daused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hemorrhapic Strok Due to (or as a consequence of):			Approximate Interval Between Onset and Death 24 hours	
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Date (Discount of the International Control of th				
P.O. Box 6	the y th iche	by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
Records, F	w requires that been signed b should be deta	ted by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	
al Reco	The law ate has b page 2 sh	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ 1	? death?	psy findings available mpletion of cause of 2 No
of Vital	Physicien: The this certificate har director, page	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 27. Manner of Death 28a. Date of Injury 28b. Time of	The second secon	n (Check only one) me 5 Residence 28d. Describe how in		y)
Division of	To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	Certification;	27. Manner of Death 1	Work? M 1 □ Yes 2 □ No	28f. Location (Street City or Town, Sta	and Number or Rura	l Route Number,
	he Hospite in 24 hours he Funerel pletely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the pasis of examination and/or invalid manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as s and place, and due to	rated. the cause(s)
	idim by	M	29b. Signature and title of earlifty	29c. License number D58681		Date signed (Month, y 31, 2005	
	(4)			etown Road Betheso	da, MD 208	314	
事	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 1 2005	٥			

Hattie

Elizabeth

Jones

the burial-transit that the death certificate be executed Box 68760 ģ Vital Records, page 2 has certificate Physician: Division of death. after death Director: ģ

212-18-617

Hatlie Jones

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mamo Teninsula noval 341/5hUn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCt. 16 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Birthplace (State or Foreign Country) 1916 1 ☐ M 2 🔀 F Months Days Hours Min 212-18-6170 88 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits Items 23a or 28a-f show Iner must be notified at 1 Yes 2 No Director Maryland Somerset Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32005 Flower Hill Church Road 21822 U.S.A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner ifed within 72 hours after ∃Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be fited withly Health and Mental Hygiene. Iem 27 Is marked other than Domestic None 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Samuel W. Harmon Hattie V.Stanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Roxbury (Sister) 621 Shaps Point Rd.Fruitland, Md. 21826 Item 27 other to 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or ^ 4 □ Donation = 5 □ Other (Specify) Green Brier Cem. 6-4-05 Eden Md. 21. Signature of Funeral Service Licenses Stewart funeral Home Stewart 821 West Rd.Salisbury, Md.21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ASOVI SYCAK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tűnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed? 2 No 1 Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funeral Directory filled in Medical 29a. Certifier 1 🗜 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) USHA NAPES AN 0051359 315 × 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. DINSION 1415 ST, SALISBURY 31. Date filed (Month JUN 0 2 2005 gistrar's Signature State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2005

PM

2. Date of Death Month

		1 - For State Registrar	State of Ma		d / Depa		it of H	ealth a	and M	-		005	20006
0		1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	V	3. Time of Death
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Exami		4a. Facility Name (If not institution, give			,	4b. City,	Town, or	Location of	of Death			County of Death	
		1 Social Security Number 6.5	Nedical 7 Age	(In vis	last birthday)	If Under	M/is	If Under	24 Hrs. 1	8. Date of Bir	th U	I CONIC	Danlace (State or Foreign
Funeral Director			1 □ M 2 1 F	58	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 12/22/	y, Year)		place (State or Foreign Intry) Vland
ס		Usual Residence of Decedent								14/44/	70	Tidi	<u> </u>
anylar show	5	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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or its	y Fu	1 Never Married 2 Married	1 Yes 2 N	o		1 ☐ Yes		Specify:		rican, otc.)		Black, White Specify: D1	_
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12 sh h and f is m raum	1	19a. Informant's Name/Relationship									er, City or	Town, State, Zi	ip Code)
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stcian: The law certificate has b irector, page 2 s	Completed									auto perfo	psy ormed? 2 13 No	prior to condeath?	
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fer fer	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o	f M	28c. Injun Worl			28d. Describe	how injury	occurred	
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St	ate	31. Date filed (Month, Day, Year)	32. Redistra	ır's Signa	ature					/	<i>y</i>		
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П	Physici	an.	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	_	3. Time of Death
	/Media		Judith L. King					05		5 2039 M
	Examir	er	4a Facility Name (If not institution, give si	reet and number)	20 la	4b. City Town, or	Location of Dea	ath	4c. County of	J
			5. Social Security Number 6. Sex	THEUCH C	s. last birthday)	If Under 1 Year	buy If Under 24 Hr	s la Data et Dist		omics
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			Usual Residence of Decedent					3-23-19	79	DE.
	nylan how		10a. State 10b. County	10c. (City, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·	10d. fnside City Limits
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	or 28	Director	10e. Street and Number		-	10f. Zip Code		1	0g. Citizen of Wh	at Country?
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	ar dea	Funeral		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (n, Mexican, Pue	Specify Yes or No- into Rican, etc.)		American Indian, White, etc.
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g	permit. Pages I Department of H Important: If Its any injury or ot once.		Shart	-alonell		Name and Addres hort Fune		e, Inc.		
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Ě	has be 2 s	Compl						24a. Was an autopsy perform	prio	re autopsy findings available or to completion of cause of
NI GIL		e Co	25. Was case referred to medical					1 ☐ Yes 2	No 1	Yes 2□ No
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5	두 두 등	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe ho		(Ѕреспу)
VISION	r Attending er death. ractor: After by the funer	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOHIII, Day Year)	Injury		? 'es 2 □ No			
<u> </u>	iracto	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number of	or Rural Route Number,
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	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exemine	r: On the bast of my kr or: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opi	e, date and place inion, death occ	e, and due to the ca urred at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
	o the	Me	29b. Signature and title of certifler	And mariner stated.		29c icense	number	. 29	d. Date signed (A	Month, Day, Year)
			1 Assistant	1		03	114		/ /	/
	100		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Tvpe∕	S _{rint)}	- N		1 -/ -	
	10		-gratius	r. Div	la d	om.	D. 10	DO E. CA.	V/011 5T.	2005 SAUSLUY MD
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	Physici /Medic		Decedent's Name (First, Middle, Last Joyce Virgin.	•							2. Date of D Month May		ay 2005	Yeer	3. Time of Death
	Examin		4a. Facility Name (If not institution, give 3415 Shiloh Road	street and nun	nber)			Town, or	Location of	of Death		4	c. County	of Death	
	Funeral Director		212-32-1000	х Эм 2 4ДF	7. Age (In yrs. 72	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Jul 2	irth Day, Yea	932	9. Birthp Cour Mary	place (State or Foreign http: yland
	h the Maryland rr 28a-f show r notified at	irector	Usual Residence of Decedent 10a. State 10b. County Maryland Carro 10e. Street and Number	11	10c. Cit	ty, Town or Lo	ocation 10f. Zip	Code	Hamps	stea	đ	10g. (Citizen of V		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
0	after death wit or items 23a c	y Funeral Director	3821 Greenmount 11. Marital Status 1 Never Married 2 Married	12. Was Dece Armed For 1 Tyes If Yes, Giv	dent Ever in Urces? 2 X No		Was Deced			074 gin? (Spi n, Puerto	ecify Yes or N Rican, etc.)	lo-		k, White,	can Indian, etc. vhite
0000-0171	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it a Madical Exaction or at the indifferent	Completed by	3 ∰Widowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 1	Year or Da	ites:	16a. Dece	dent's Usua kind of wo DO NOT us HOMET	al Occupa rk done d se retired	ation during mos	t of work	ing	16b.	Kind of Bu		dustry
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	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any injury or other traumatic.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify))	State Gre	Place of Dispondent Commentary, created the Commount Commo	matory or o	ther plac		06/02	2/2005	Н	Location - ampst	cead,	
0	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	W.	900723 Cm	22	2. Name an 934 S				Eline I , Hamps				74
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INISION OF	To the Hospital or Attending Physician: within 24 hours stafer death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: 1	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		h, Day Year)	28b. Time o	М			No	28d. Describe	how in	ury occurr	ed	al Route Number.
2	spital or A ours after neral Dire filled in by		4 Homicide determined 29a. Certifier 1 Certifying Phy		of Injury - At h				e date an		City or To	own, Sta	ite)		
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			29b. Signature and title of certifier				\mathcal{P}	License	701			5	131	/O	Day, Year)
	Q. 80		30. Name and address of person who of Dr. Deogracias Fa					vill	e Rd,	Ham	pstead	, M	210	74	
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa	-	6	. .							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2<u>005</u> Month **Physician** 22, 11:35 PM Dorothy Davis May Lucas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01nev Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Unk. 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 ☐ M 2 🗓 F 97 578-56-2277 Director 01-11-1908 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f show other treumetic event, If a Manical Examinar must be notified at 1 □XYes 2 □ No Silver Spring Director Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "" any injury or other treument." 2921 No. Leisure World United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Unknown 1 Yes 2 No Specify: Unknown 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher DCPS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Abraham Davis Gabrielle Beale Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smith Davis/Nephew 4208 Kimbrelee Ct, Alexandria, Va. 22309 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 5/28/2005 Ft. Lincoln Brentwood, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration pneumonia /Medical Due to (or as a consequence of): **Examiner** Recurrent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Multiple Joint Osteoarthritis Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Hypertension Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 Xo 3 Probably 4 Unknown Sepsis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performe 1 Yes 2 No 1 Yes 2 XNo To the Hospitel or Attending Physicien: after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes X No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funerel L

completely filled 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00019981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUKEMIT Abole 110 20785 6005 Landover Rd. Cheverly, MD 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 0 1 2005 Registra

		1 - For State Ragistrar	State of Mar	yland /		rtment of F				iene	005	20010
		Decedent's Name (First, Middle, Las	t)						2. Date of Deat	h		3. Time of Death
Physic /Med		Asuncion H	Robledo L	opez					May 28,	2005	Year	9:45 PM
Exam		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	r Location	of Death		4c. Cou	inty of Deat	
		Manor Care				Poton					Mon	tgomery
Funera	_	5. Social Security Number 6. So	□M 2127 E	(in yrs. last	birthday) Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, June 29	Year)		nplace (State or Foreign untry)
Directo	r	579-84-0380 'Usual Residence of Decedent		90	115.				June 29	,1914	Spa	ain
land ow		10a. State 10b. County	1	10c. City, To	own or Lo	cation	-					10d. Inside City Limits
Mary I sh	į	DC No	one		Wasl	hington						1 ☐Yes 2 ☐ No
h the	Director	10e. Street and Number	-			10f. Zip Code			1	0g. Citizen	of What Co	untry?
th wit	a D	2927 Ordway Sti	ceet, NW			20	8000			S	pain	
iled within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. Hyberthen "naturel", or Itamis 23a or 28a-f show ant, ir a Meulical Experience must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. \	Nas Decedent of H	ispanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian,
s afte	by Fu		1 ☐ Yes 2 ☐ ¥No If Yes, Give			I ☐ Yes 2 ☑ No	Specify:		, , , , , , , , , , , , , , , , , , , ,		noife.	
hours ural	d b		Year or Dates:	1 44	Ĉa Desse		- 41		-		WI	nite
n 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Give (Give life l	lent's Usual Occup kind of work done o DO NOT use retired	ation during mos	t of working	ng	16b. Kind o	f Business/	Industry
with iene. the	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	,		nemaker	,				Own I	Home
Hyg other	O	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle, I	Maiden Sun		
Ind be denta	ToB	Rafael Robledo					Pε	etra	Fresno			
s ma		19a. Informant's Name/Relationship (7	Type, Print)	1	9b. Mailin	g Address (Street	and Numbe	er or Rura	Route Number	City or To	wn, State, Z	(ip Code)
and 2		Ralph Lopez/Son			2630	Colston	Dr.,	Chev	y Chase	, Md.	2081	5
of He roth		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	Removal from State	20b. Place ceme	of Dispos etery, crem	sition (Name of natory or other place	ж)	D	ate	20c. Locatio	on - City or	Town, State
Pag ment ant: i		`4 □Donation 5 □ Other (Specify		Mt.		et Cemete	1		2,2005			n, DC
pertilition of the first product of the first percentage of the Marylan Department of Health and Mental Hygiene. In portant: if item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other preumatic event, Ita Medical Examinating the nutilities.		21. Signature of Funeral Service Licen	seb//			. Name and Addre						
40500	k	hum XX	14			222 Wisco					ton,Do	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	ne death. D	o not ente	er the mode of dyin	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Cardiac									Sudden
/Medica Examine			Due to (or as a c Hyperten		ce of):							01.1
	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c		ce of):							01d
uted I Insit	E	cause. Enter Underlying Cause (Disease or injury	Atherosc	cleros	sis							01d
execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a c									
cate be executed physician and the burial-transit	dicall		d									
	ed											
Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2			Ectopic pregnancy	,				Date of deli	
e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at tin			Other (specify)					Month	Day Year
d by t	Phy	9 Unknown							00. 5:44-1			
res the signer	þ	Dementia	ontributing to death but i	not resulting	g in the ur	noerlying cause giv	en in Parti	١,				the cause of death?
requi	eted								-		3 2 7	Doably 4 GOTKHOWN
e law has b	ompleted	•							24a. Was a autops	V	prior to d	topsy findings available completion of cause of
icate	O								perform 1 Yes 2	No	death?	2 No
certifi rector	Be		Hospital:			Oth			(Check only on			
This ral di	To	1 Yes 2 No	1 Linpatient		Outpatien b. Time of	t 3 DOA	vat		ne 5 Reside			city)
th.	ton	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	Year)	Injury	Wor	k? Yes 2□			,,		
Atter r dea ector	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	y - At home,	, farm, str	eet, factory, office		2			ımber or Ru	ral Route Number,
s after	Certification:	4 Homicide	building, etc. ((Specify)		-			City or Town	, State)		
To the Hospitel or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a			ysician: To the best of	my knowled	dge, death	occurred at the tir	ne, date ar	nd place, a	nd due to the ca	use(s) and	manner as	stated.
he Hi in 24 he Fu pletet	Medical	(Check only 2 Medicel Exam	niner: On the basis of ex and manner state	xamination	and/or inv	estigation, in my o	pinion, dea	ath occurre	at the time, da	ate and plac	ce, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	0			29c. Licens	e number		2	9d. Date sig	gned (Monti	n, Day, Year)
V		Laises	FIND			D3:	1319			May	31, 2	005
		30. Name and address of person who										
		Loreto Albiol,			-		ite 1	03, B	ethesda	, Md.	2081	4
Pogis	tate	31. Date filed (Month, Day, Year)	P. Registrar's	s signature	Ross	Es.						

			1 - For State Registrar	State of Marylan	-	artment of rtificate o			Reg. No.	005	20011
	Physicia /Medic		Decedent's Name (First, Middle, L LAC	ast)	I	ĽΕ		2. Date of De Month May	30 Day	20 ^v 65	3. Time of Death
>	Examin		4a. Facility Name (If not institution, g Magnolia Gardens			4b. City, Town Lanha	, or Location of M	Death	4c. Co	ounty of Death INCE G	eorge's
	Funeral Director		216-31-3477	Sex 1 □ M 2 □ F 7. Age (In yrs. 80		Months Day		Min. 8. Date of Bi (Month, D April	rth ay, Year) 11,19:	9. Birthi <i>Cou</i> V1	place (State or Foreign ntry) CCNAM
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		y, Town or Lo	ocation					10d. Inside City Limits
	death with the Maryland	Il Director	10e. Street and Number 8200 Good Luck R	load		10f. Zip Code	20706	5		n of What Cou tnam	ntry?
		by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Control of Yes 2 N N		in? (Specify Yes or N Puerto Rican, etc.)		Race - Ameri Black, White, pecify: AS1	etc.
21215-0036	J within 72 hours after jiene. r than "natural", or he tre Medical Examir s	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work doi DO NOT use ret et Polic	ne during most ired)	of working	16b. Kind Sout Gove	-	
2	2 should be filed and Mental Hygis Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Las Hoa	Le			18. Mother MeO	's Name (First, Middle	a, Maiden Su	imame)	Vo
Mary	nd 2 sho alth and h 27 is ma ir trauma	•	19a. Informant's Name/Relationship Ngoan Le -daughte		19b. Maili 6904	ng Address (Stre Presle)	et and Number 7 Road I	or Rural Route Numb Lanham, Ma	er, City or I ryland	own State Zij 20706	o Code)
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of Control	□Removal from State	emetery, cre	osition (Name of matory or other p metery	olace)	Date /2/2005		tion - City or To	own, State e, Maryland
Bair	permit. Departn Importa any inju		21. Signature of Funeral Service Lic	Bugward		onald V.	Borgwaler Mill	ardt Funer l Road Bel	al Hom tsvill	e, PA e, Mary	yland20705
eo,	Physician /Medical Examiner	Ical Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infrated events resulting in death) Last	ly one cause on each line.	uence of):	ter the mode of g	lying, such as c	ardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
BOX 6	ath certific attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	□Ectopic pregna □ Other (specify)			230	d. Date of delive	ery Day Year
cords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	Inderlying cause	given in Part I.		tobacco use		he cause of death?
Hec	The lar	Completed						24a. Wa. auto perf		24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
=	ysiclan: is certific director,	o Be	25. Was case referred to medical examiner?	Hospital:			24	of Death (Check only			
0	ding Phy. h. After this funeral d	-	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time of	III JUDOA	4 Nur	sing Home 5 Res			(y)
0	th. Afte	ig ig	1 Natural 5 Pending 2 Accident investigati		Injury		Vork? □Yes 2□N	0			
DIVISION	To the Hospital or Attending Physician: within 24 hours after death or 17 to the Funeral Director. After this certifica completely filled in by the funeral director, it	Certification:	3 Suicide 6 Could not 4 Homicide determine		ome, farm, st	reet, factory, office	Ce Ce	28f. Location City or To	(Street and Nown, State)	lumber or Rura	al Route Number,
	the Hospi in 24 hou the Funer pletely fill	edical	29a. Certifier 1 Certifying f (Check only one) 2 Medicel Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated	owledge, deat ition and/or in	th occurred at the evestigation, in m	time, date and y opinion, death	place, and due to the n occurred at the time	cause(s) an date and pla	d manner as s ace, and due to	stated. o the cause(s)
	V Com	Σ	29b. Signature and title of certifier			Ž9c. Lice	H86	77	29d. Date s	igned (Month,	Day, Year)
			30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type,	Print) Al	exen	der E	207	UV 0	hung
9	Sta Registr		31. Date filed (Month, Day, Year)	33 Registrar's Signa	ature de	we					

			For State Registrer	State of Maryland /	Depa		ealth and I	Mental Hy		2005	20012
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) FRANCES 4a. Facility Name (If not institution, give so CHERRY LANE NU	street and number)	LAWS	ON 4b. City, Town, or LAUI		2. Date of De Month MAY	30 4c. 0	Yeer 2005 County of Death	3. Time of Death 8:55P M
	Funeral Director		5. Social Security Number 6. Sex 245-72-6546 Usual Residence of Decedent	7. Age (In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da July 21	th y, Year)	9. Birthp Cour L2 North	place (State or Foreign ntry) n Carolina
	th the Maryla or 28a-f shov e notified at	Director	10a. State 10b. County MD PRINCE GE 10e. Street and Number	EORGE S BELTS					10g. Citiz	en of What Cour	10d. Inside City Limits 1 X Yes 2 □ No ntry?
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23e or 28e-f show event, tre Modical Examinating and the notified at	by Funerai D	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		20705 Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Sin, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 1	S.A. 4. Race - Americ Black, White,	etc.
Maryland 21215-0036	d within 72 hou giene. ar than "natural	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 5 th	cation 16	(Give life. l	dent's Usual Occupa kind of work done of DO NOT use retired SE WIFE	ation during most of wor)	king		BLAC d of Business/In	
ryland	hould be file id Mental Hy, marked othe matic event.	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN 19a. Informant's Name/Relationship (Ty)	pe Print)	9b Mailir	ng Address (Street a	18. Mother's Nam	GOOD	ING		a Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Modical Examiner must be notified at ODGE.		MAE WHITEHEAD / DAU 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	GHTER 1 20b. Place ceme South	of Dispo tery, cren view	CEDAR LA sition (Name of natory or other place Cemeters Name and Address	ANE BELTS 7 6/4/ is of Facility J.	Date /2005 B. Jenl	MARYI 200. Loo Kings kins	AND 20 ation - City or To ston, Nor Funera1	own, State th Carolina Home
760,	physician and physician and street street is the burial-transit	icai Examiner	23a. Pan1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate List of the condition of the conditions of t	Aspiration Propue to (or as a consequence Hypertension Due to (or as a consequence Congestive House to (or as a consequence Due to (or as a co	neumer of): e of): eart	onia				ial y land	Approximate Interval Batween Onset and Death
.O. Box 68	ires that the death certifica signed by the attending ph d be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23	Bd. Date of delive Month	ery Day Year
Records, P	The law requate has been page 2 should	Completed by Ph	Part II. Other significant conditions con Dementia	tributing to death but not resulting	j in the u	nderlying cause give	en in Part I.	1 🗆 \ 24a. Was autop	rmed?	No 3 Prob 24b. Were auto prior to cor death?	ne cause of death? pably 4 □Unknown psy findings available mpletion of cause of
Division of Vital	ding Physician: h. After this certific funeral director.	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 Xalural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	. Time of Injury	28c. Injury Work M 1 🗆 Y	26. Place of Dea er: 4 ☑ Nursing H at er: 2 ☐ No	ome 5 ☐ Resid 28d. Describe h	dence 6 now injury	occurred	
DİX			4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, building, etc. (Specify)	lge, death	occurred at the tim	e, date and place	City or Tov	vn, State) cause(s) a	nd manner as si	d Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	and/or inv	29c. License	number		29d. Date	signed (Month,	Day, Year)
	2		30. Name and address of person who con Andrew Kundrat M			,		and 2070		31, 200	3
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 2005	Registrar's Signature	Son	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item #1 & 5 per dr/fiCertificate of Death wichd/6-6-95/dls 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5 **Physician** Susan W Lilley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Salisbur Wicomico Hospice Ke at Birthplace (State or Foreign Country) If Under 1 Year Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😡 F Director 51 6/22/1953 -218-48-5432 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov 7 is marked other then "naturel", or Items 23a or 28a-f show traumatic event, the Medical Evanirar must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 28711 Log Cabin Road 21801 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ₩ No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Retail 12 Sales s 1 and 2 should be filed w Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilson T. Webster Nanetta W. Reddish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 i Nanetta W. Phillips/mother 28955 Log Cabin Rd., Salisbury, MD 21801
Disposition (Name of Date 20c. Location - City or Town item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ŏ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department o Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 5/31/05 Salisbury, MD 21. Signa mater Europeal Se lice License 22. Name and Address of Facility Holloway Funeral Home Professional Association Holloway Funeral Rollie Floresse

Holloway Funeral Rollie Floresse

For Sold Snow Hill Rd., Salisbury, MD 21804

Approximate Interval Between Rock, or heart failure. List only one cause on each line.

Approximate Interval Between Rock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes Division of Vital To the Hospitel or Attending Physicien:

Completed by Be P After Director

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Certification: in by the

25. Was case referred to medical examiner? 1 Tes 2 No

27. Manner of Death Natural 2 Accident 3 🗌 Suicide 4 Thomicide 29a. Certifier

5 Pending investigation 6 ☐ Could not be determined

Hospital: npatient Date of Injury (Month, Day Year)

2 ER/Outpatient 28b. Time of

28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death teu 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

0. BX1733 SALISBURY MD 2180L

State Registrar

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COASTAL HOSPIKE 31. Date filed (Month, Day, Year) MAY 3 1 2005

death.

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within 24 hours a To the Funerel [

Funeral Director with the Maryland

or 28a-f show

the Medical Examiner must be notified at

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"natural"

Hygiene.

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within 24 hours a To the Funeral C

29a. Certifier

(Check only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

John Paul Vistoli

JUN 0 2 2005

Medical

0

Registrar DHMH 17 Rev 1/2001

State

Director

Completed by Funeral

Be

ပ

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

221-16-2101

10e. Street and Number

10a State

Usual Residence of Decedent

Delaware Sussex

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Augustus Long

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

Ollie Cannon (Sister)

1 Burial 2 □ Cremation 3 □ Removal from State

Ann

10b. County

Facility Name (If not institution, give street and number)

400 Holly Court Apt. 403

15. Decedent's Education (Specify only highest grade completed)

Long

Regional Medient

1 □ M 2 5 F

filed within 72 hours after death 21215-0036 Maryland s 1 and 2 should be fi f Health and Mental H item 27 is markad ott Baltimore, Pages

Springhill Mem.Garden 6/05 Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Stewart Funeral Home Hladya lewar 821 West Rd.Salisbury, Md.21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final chronu obstructive Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) ASCUD Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an has autopsy performed? certificate 1 Yes fo the Hospital or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Plopatient 2 □ ER/Outpatient 3 □ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 14 Natural 5 Pending 1 🗌 Yes after death. 2 🗆 No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

address of person who completed cause of death (Item 23a) (Type, Print)

32. R

3. Time of Death

1933

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Tyes 2 No

9. Birthplace (State or Foreign

Mary land

0	R	l	G	IN	IA	L

100 E. Carroll

strar's Signature

Xcartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

HO059368

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10f. Zip Code

1 ☐ Yes 2 No

Domestic

20b. Place of Disposition (Name of cemetery, crematory or other place)

19940

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Center

Yrs.

10c. City, Town or Location

Delmar

7. Age (In yrs. last birthday)

83

12. Was Decedent Ever in U.S. Armed Forces?

☐Yes 2 No

College (1-4or 5+)

If Yes, Give

Year or Dates

4b. City Fown, or Location of Death

alisbury

2. Date of Death

Month

05

18. Mother's Name (First, Middle, Maiden Sumame)

Mary Dashield

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

570 Village Ct.Salisbury, Md. 21801

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 29, Year 21

Day

3 c

Year

07

4c. County of Death

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

Hebron, Md.

23d Date of delivery

29d. Date signed (Month, Day, Year)

5/3//05

MD

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

25 No

U.S.A

None

Wicomice

			1- For State of Maryland / Department of Maryl	artment of Health and M		iene eg. No.	20015
			Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h	3. Time of Death
	Physicia /Medic		Doris Jean Lemarr		May 28,	Day Year 2005	10:45 M
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		d	Snow Hill Nursing Home	Snow Hill		Worceste	r
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 5.77	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Con	nplace (State or Foreign untry)
L	Director		377-40-7737 74		1/25/19		th Carolina
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	laryl sho	ō	Maryland Worcester Snow Hi	1.1			Y Yes 2 □ No
	28e-	ect	Maryland Worcester Snow Hi	10f. Zip Code	11	0g. Citizen of What Co	untry?
	with Ba or	ō	430 W. Market St.	21863			,
	death ms 23	Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	city Yes or No-	USA 14. Race - Amer	rican Indian,
ထ	or ite	Für	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No		Rican, etc.)	Black, White	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show Jical Examiliar must be natified at	l by	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	white
2-0	72 honatu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working	ng	16b. Kind of Business/I	ndustry
2	within iene. • than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Domestic	
	filed w Hygier other tl	Ö		ewife	(First Middle A		
and	be fi	Be	17. Father's Name (First, Middle, Last) Carl Samual Duckett	18. Mother's Name			
ž	should Ind Men	ို		ng Address (Street and Number or Rura		eth McMahor	
Maryland	d2sl than 7 tsr traur						ip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Extendent cuts be natified at ones.			1 Shell Rd. Delma osition (Name of matory or other place)		1875 20c. Location - City or 1	Town, State
Baltimore,	Pages nent of t int: If its iry or o		T Buriar 2 Grandation 3 Harmovaritom State			evance and reserve	
Ħ	artme artme ortan injur		2 Signature of Funeral Service Loginsee	y Crematory 5/31 2. Name and Address of Facility		Salisbury,	
Ba	permit. Departr Importa any inj		No Viole	Holloway Funeral H	ome Pro	fessional A	ssociation
			Za. Part1. Enter the disease, or complications that aused a death. Do not ent	ter the mode of dying, such as cardiac o	Salishi r respiratory arre	ury MD 218 est,	Approximate
			Immediate Cause (Final	Λ O	1 11		Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death) Due to (or a a consequence of):	baseles 1	race of	us	
r	Examiner		Course	Diabetes 1 Sectery Di	sease	_	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of the Property of Causa (Disease of the Property of the Pro	1			
	cuted nd ransi	Examiner	that initiated events c.				
ó,	ate be executed hysician and ihe burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,		Physician/Medical	d				
9	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as i	Mec	IF FEMALE:				
Вох	ath c	ian/		⊒Ectopic pregnancy		23d. Date of deliment	very Day Year
P.0.	the s	ysic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			
	that the de led by the s detached I		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Vital Records,	uires that signed I	d by	Renal Failme		1 □ Ye	s 2 No 3 Pro	obably 4 Unknown
Sol	w requir been si should	Completed			24a. Was a	n 24h Were aut	topsy findings available
Re	sicien: The lav certificate has rector, page 2	mo			autops	y prior to c ned? death?	ompletion of cause of
g	in: T.	e C	25. Was case referred to medical	26. Place of Death			2□ No
5	ysicie is cert directe	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	0.1		ence 6 □Other (Spec	WA.
of	Attending Physicien: r death. ector: After this certific by the funeral director.	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time o			w injury occurred	ary)
ion	nding F ath. r: After e funer	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No			
Division	il or Attendi after death. I Director: A d in by the fu	iffici	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,
	tal or s afte al Dir ed in	Certification;	building, etc. (opechy)		0.1, 0.7, 70.11.1	, otalo,	3
	e Hospital 124 hours a e Funeral I letely filled		29a. Certifier (Check only (Ch	h occurred at the time, date and place, a	and due to the ca	ause(s) and manner as	stated.
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	one) and manner stated.				
	viti Con	~	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month	
•	90					2 28	0.5
	18		30, Name and address of person who completed cause of death (Item 23a) (Tope,	Print)	MI)	21851	
	Sta	te.	31. Date filed (Month, Day, Year) 32. Findistrar's Signature	1			
	Registr		30, Name and address of person who completed cause of death (Item 23a) (Tope, 16 of the completed cause of death (Item 23a) (Tope, 16 of t	parle			

		State of Maryland / Dep 1 - State Amend Items 24a,25,26,27,29 J	artment of Health and Men	tal Hygieno 5dhb	2005 20016
6		Decedent's Name (First, Middle, Last)	2. [Date of Death Month Da	3. Time of Death
Physic /Med		James Phebus Landis			29, 2005 8:20p ^M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
		Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Frederick If Under 1 Year If Under 24 Hrs. 8, [Date of Birth	rederick
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 150 M 2 F 7. Age (In yrs. last birthday 217-28-1448	Months Days Hours Min.	Month, Day, Year	
		Usual Residence of Decedent		211 14, 1	
arylan show	_	10a. State 10b. County 10c. City, Town or L Maryland Frederick Fr			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ith the Marylan or 28a-f show	Director		ederick	10- 0	itizen of What Country?
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or Items 23e or 28e-f show ont, the Madical Examiner must be notified at any.	ក	10e. Street and Number 5912 Quinn Road	10f. Zip Code 21701	109. 0	U.S.A.
72 hours after death w "natural", or Items 23a	Funeral		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian,
or Ite	Fur	1 Never Married 2 Married Armed Forces? 1 Na Yes 2 No 1949 - If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	n, etc.)	Black, White, etc. Specify: White
aral',	dby	3 Widowed 4 Divorced Year or Dates: 1969			WILLE
"natu	ete	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. F	Kind of Business/Industry
withii iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Chi	ef Boatswain's Mate	Un	ited States Navy
and Mental Hygiene. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ire M.	0	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir	st, Middle, Maide	n Sumame)
should be and Mental marked oumatic even	To B	John Bennett Landis	Sr Bertie		Phebus
1 c, IVI at I yill with the Maryla stand 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. It marked other than "natural", or Items 23a or 28a-f show the traumatic event, Ire Medical Examiner must be nutified at	10		ing Address (Street and Number or Rural Ro		
C, n 1 and 1 ealth 1 ealth 1 ealth 1 her ti		Catherine Postin Landis/Wife 5912 20a. Method of Disposition 20b. Place of Disp	Quinn Road, Frederi		land 21701 ocation - City or Town, State
permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr		1 VBurial 2 Cremation 3 Removal from State	n Mem Gar Jun 2, 200	_	
nit. Pa artme ortant injury			22. Name and Address of Facility	J 11	ederick, Maryland
Den de		23a. Part1. Enter the disease, or complications that caused the death. Do not en	Keeney & Basford P.	A. Funer	al Home
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or res	rederick spiratory arrest,	, Mary Land proximate Interval Between
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/Medica	ı I	resulting in death) Duy to (or as a consequence of):	1 /		
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ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bount lailwe	ę	
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The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ical	d			
rtifical	Jedi	IF FEMALE:			
v requires that the death certifics been signed by the attending phe should be detached for use as the standard of the same that	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
the all	sici	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)		
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w requires been sign should be	d by			1 ☐ Yes 2	No 3 Probably 4 Unknown
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The la	omo			autopsy performed? 1 ☐ Yes 2 ☑ No	prior to completion of cause of death?
	Be C	25. Was case referred to medical examiner?	26. Place of Death (Ch	A_	
Physic This ce	Tof	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatie			
ing P	on:	27. Manner of Death 1 Tatural 5 Pending (Month, Day Year) 28b. Time Injury	Work?	Describe how inju	ury occurred
Attending r death. Sector: Atte	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Tyes 2 No	Location (Street a	nd Number or Rural Route Number,
after Direction by		4 Homicide determined building, etc. (Specify)		City or Town, Stat	
pspite hours uneral y fille	Salc	29a. Certifier Certifying Physician: To the best of my knowledge, dea			
To the Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Chack only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
To Too	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
		ff far M.D.	D006087		3/30/2005
10		30. Name and address of person who completed cause of death (Item 23a) (Type Michelle Tan, M.D., 400 West Seven	th Street, Frederick	Marvla	nd 21701-4506
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	
Regi	strar	JUN 1 5 2005 Beau & Sparte			

DHMH 17 Rev 1/2001

34 a, 35, 26, 37, 39a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Michael Stephen McDonald, Sr. May 2005° 26, 10:18A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March4, 1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F 216-60-4890 52 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location orrant: It itam 27 is marked other than "natural", or itams 23a or 28a-1 show injurge other traumatic event, the Medical Examinar must be notified at 8. 10d. Inside City Limits Maryland Prince George's Beltsville Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10604 Taunton Court 20705 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married XYes 2 □ No Yes, Give 10 1 ☐ Yes 2 📉 No Specify: Specify: White r tes, Give Year or Dates: 1971-1974 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) Sales Self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I of Health and Mental James E. McDonald Elizabeth M. Jones ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. McDonald -wife 10604 Taunton Court Beltsville, Maryland 20705 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Maryland Veterans Cem. 6/3/2005 Cheltenham, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA any la Horald 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ovolvary artery disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner percholesterole Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit egenerative and resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Lementia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 2 page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 🗌 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pendina investigation 1 Yes 2 No efter death Director: 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 27, 2005 Md H0062176 Dununang 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) Swarna Tammana, P.O. 2415 Musgrove Road, #105 Silver Spring, Maryland 20904

Registrar

State

31. Date filed (Month, Day, Year)

JUN 0 1

2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Day 200⁵5° **Physician** Charles Edman McIntosh 24, 11:27P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 24, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2□ F Months 77 Yrs. 577-32-9689 North Carolina Director Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic avent. It is Mischell Examities matched any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5809 Goucher Drive 20740 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by unk 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Power Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Homer McIntosh Lois Hutchens 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5809 Goucher Drive College Park, Maryland 20740 Carolyn S. McIntosh -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 5/27/2005 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA
4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complication sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Sepsis 4 days /Medical Due to (or as a consequence of): Examiner 4 days Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus; Deydration; Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 ₹ No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural after death.

Diractor: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pellil within 24 hours a To tha Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 May 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, M.D. 14333 Laurel Bowie Road, #208 Laurel, Maryland 20708

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 1

2005

			1 - For State Registrar	State of Maryla		artment of rtificate o		Mental Hy	giene Reg. No. 2	105	20019
	Physicia /Medic		1. Decedent's Name (First, Middle, Last, FRED K MC	INTOSH				2. Date of Do Month	Day	Year 200.5	3. Time of Death 12:20 FM
	Examin Funeral Director		5. Social Security Number 6. Se	MARYLAND M	. last birthday	ENTER		B. Date of Bi	rth ~		ace (State or Foreign ny) 1and
	D	or	Usual Residence of Decedent 10a. State 10b. County WV Berkely		ity, Town or L Inwood	ocation					d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the 1 3a or 28a- It Le notifi	Funeral Director	10e. Street and Number 99 Tocoma Court			10f. Zip Code	428		10g. Citizen of		•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highry or other traumatic event, I'm Medical Evarili or must be notified at any highry or other traumatic event, I'm Medical Evarili or must be notified at any higher.	by Funera	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puer lo <i>Specify</i> :	Specify Yes or N to Rican, etc.)		ce · America ack, White, e	itc.
21215-0036	within 72 horenene. ene. than "naturi	Completed	15. Decedent's Edu (Specify only highest grad		(Giv	edent's Usual Occ e kind of work dor DO NOT use reti	ne during most of wo ired)	orking	16b. Kind of E		ntenance
Maryland 2	buld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Leslie Jene McInt				Joanne	me (First, Middle e Junkin	e, Maiden Suma	me)	
e, Mar	1 and 2 sho Health and Im 27 Is m		19a. Informant's Name/Relationship (T) Laura M. McIntosh 20a. Method of Disposition	(Wife)	99 T	ing Address (Street OCOMA CO	ourt Inwo	od, Wes		nia 25	428
Baltimore,	nit. Pages lartment of hortant: If its injury or of		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ↓ icens	Removal from State Ri	cemetery, cre cketts	Family Family Region of the	Cem. 20	e 1, 005 eVol Fun	Derwood	l, Md.	, ciato
B	permit. Departr Importu any inji	V 1 6	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea			Deer Park	Dr. Gai	thersbu		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	Due to (or as a consection of the consection of	A PN	EDMON	1A				Orision and Poderi
,8260,	death certificate be executed e attending physician and ind for use as the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of a DIOPATH	quence of):						
.O. Box 6	9 4 9	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preging the pregnant at time of good Unknown	tal death 3	□Ectopic pregnal □ Other (specify)				ate of deliver	y Day Year
rds, P	sign sign d be	by	Part II. Other significent conditions co	ntributing to death but not re	sulting in the	underlying cause	given in Part I.		tobacco use cor Yes 2 □ No	ntribute to the	e cause of death?
Vital Records,	The ate h page	Completed						1 Yes	opsy ormed? 2 \square No	prior to con death?	sy findings available apletion of cause of No
V.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Other	ath (Check only			
of	ding I. After funei	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. in	4 🗆 Nuising	Home 5 Res 28d. Describe	how injury occu)
Division	spital or Attending ours after death. neral Diractor: Atte filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At building, etc. (Spec	home, farm, s hify)	treet, factory, office	ce .		(Street and Num own, State)	ber or Rural	Route Number,
	Ho Fur	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, dea nation and/or i	ith occurred at the nvestigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time	a cause(s) and m , date and place	nanner as sta , and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	4		29c. Lice	ense number		29d. Date sign	ed (Month, L	Day, Year)
	D		20. Name and address of person who co	ompleted cause of death (lite	VЧV) эт 23а) (Туре	AUH (AUH)	176435519	288.8	May 2	6,20	
			Rachel Salit 31. Date filed (Month, Day, Year)	22 Sour	H GR	EENE	STREET	BAL	TIMORE	MI	>
	Sta Regist		IIIN 0 1 200		A GOS	de					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Pasene Month **Physician** Matina Maisu Year 27, May 2005 6:15A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10115 Phoebe Lane Adelphi Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Yrs. Director 575-90-6875 51 AmericanSamoa March20,1954 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "netural", or Itams 23a or 28e-f show the Medical Examiner must be notified at Prince George's Maryland Adelphi 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10115 Phoebe Lane 20783 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: Polynesian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Engineer Private schools permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth. any injury or other treasment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasene Maisu Pupa Faleafine P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette M. Maisu -wife 10115 Phoebe Lane Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Anemoval from State San Diego, California Allen Bros Mortuary 5/30/2005 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hepatic Failure /Medical resulting in death) Due to (or as a consequence of): Examiner Stromal Cell tumor Gastrointestinal Sequentially list conditions, flary, leading to inniversal cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 Yes 2 No 1 Yes X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 🎇 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 256. Signature and title of certific D23743 May 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin David Weltz, MD 7525 Greenway Center Drive, #205 Greenbelt, Maryland 20770

Registrar

31. Date filed (Month, Day, Year) JUN 0 1 2005



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For State	State of Marylan	d / Departme			d Mental Hy	giene	005	20021
	_		Registrar Decedent's Name (First, Middle, Last	<u> </u>	30			2. Date of D	eath		3. Time of Death
	Physicia				tchell, J	r.		May 2	7, 2005	Yeer	3:10 P M
	/Medio Examin		4a. Facility Name (If not institution, give		· · · · · · · · · · · · · · · · · · ·		r Location of De			ounty of Death	1
	E Adillii	•	Marshall's Corner	Rd @ Turkey H	iill Rd La	a Plat	ta		Ch	narles	
	Funeral Director		217-98-9913	7. Age (In yrs. 37)	last birthday) If Und Yrs. Month	der 1 Year ns Days	If Under 24 H Hours M	lin. 8. Date of B (Month, D June 1	lav Year)	Cou	place (State or Foreign intry) y l and
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location						10d. Inside City Limits
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	3a or	0	1204 Adams Rd.			20602			US	A	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was De	cedent of H	lispanic Origin?	(Specify Yes or Nerto Rican, etc.)	10- 14.	Race - Ameri Black, White	
98	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Medical Erai: ili ar Fraial Le rixdiffed at	y Fu	1 X Never Married 2 Married	1 □Yes 2 💢 No If Yes, Give		21X No	Specify:	10.10 1110411, 010.7			ite
Ö	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Decedent's U	sual Occup	ation		16h Kind	of Business/Ir	ndustor
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212	with jiene. r thar	mo	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+)	Sheet M	leta1	Technic	cian	Fab	ricato	r
שַ	e filec othe vent,	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middl	e, Maiden Su	mame)	
/lar	uld by Menta arked	To E	William Matthew	Mitchell, Sr.			Marga	ret A. K	uhn		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic event, the Medical Exact metrinal be notified at any or other traumatic event, the Medical Exact metrinal be notified at anone.		19a. Informant's Name/Relationship (7		19b. Mailing Addre						ip Code)
6,2	1 and 1ealth 9m 27 1har t		Vince Giovannetti		T IZU4 AGa Place of Disposition (/		., Wale	Date	20602	tion - City or T	Town State
וסר	iges in of h		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crematory of	or other plac		-03-2005		orf, M	
Itim	it. Partmer intmer injury		 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen 		inity Mem.		ens Uo	-03-2003	Walu	011, 11	U
Ba	permi Depa Impo any ir			101240	Hun	tt Fu	neral H	lome Waldorf,	MD 20	604	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the deat one cause on each line.						001	Approximate Interval Between Onset and Death
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	/Medical Examiner		1	Due to (or as a conseq	(uence of):						
		er	Sequentially list conditions, if any, leading to infinediate	b. Due to (or as a conseq	rience off):						*
	uted d ansit	Examiner	any, leading to finine data cause. Enter Underlying Cause (Disease or injury that initiated events	C							
o,	an an rial-tr		resulting in death) Last	Due to (or as a conseq	quence of):						
8760	the death certificate be executed y the attending physician and tched for use as the burial-transit	dicai		d							
9	eath certific attending p	/Mec	IF FEMALE:	22a If you guiteema of progra	2004						
Вох	attenc for us	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3 Ectopic	c pregnancy	/		230	d. Date of deliv Month	Day Year
o.	at the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	Jean Julien	(Specify) _					
Ф	that the		Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause giv	en in Part I.	23e. Dio	tobacco use	contribute to	the cause of death?
Records,	law requires that as been signed b 2 should be deta	ed by						_ 10	Yes 2	√o 3 🗆 Pro	bably 4 Unknown
CO	aw requir is been si 2 should	pieted						24a. We			opsy findings available
	The la ate ha page 2	6						per 19 res	opsy formed? 2 \(\subseteq \text{No} \)	death2	ompletion of cause of
Vital	ician: certifica rector, p	BeC	25. Was case referred to medical examiner?				26. Place of I	Death (Check only	one)		
of V	d is	To	1X Yes 2 □ No		ER/Outpatient 3	DOA Oth	4 🗆 Nursin				ity) at scene
	ding Ph h. After th funeral	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?		how injury o		DET WITH TIMELLE
sio	or Attending after death. Director: After in by the fune	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	0 2	15.008 M		Yes 2 No				ral Route Number,
Division		ertification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		tory, office		City or T	own, State)	LISE	SAMU BOS
_	To the Hospital or within 24 hours after To the Funeral Direction completely filled in	O	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my kno	owledge, death occur	red at the tir	me, date and pl	ace, and due to th	e cause(s) an	d manner as	stated.
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	(Check only 2 Medical Exemone)	niner: On the basis of examina and manner stated.	ation and/or investigat	ion, in my a	ppinion, death o	ccurred at the time	e, date and pla	ace, and due	to the cause(s)
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)			Mountes Un	Mule MP		OCI	ME		May 2	28, 200	05
5	200		30. Name and address of person who			11 D-	C+	ot Dole	mores	Mo 1 -	and 21201
prés	000		31. Date filed (Month, Day, Year)	JURGU 32. Posistrar's Signa		TT Per	n Stree	et balti	more,	пагута	and 21201
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			Please		aryland / Depa	artment of He	ealth and Me	_	_	20022
			Registrar		Cer	tificate of D			g. No.	The Control of the Control
	Physici	an	Decedent's Name (First, Middle, Las	11)				2. Date of Death Month	Day Year	3. Time of Death
	/Media			arner	Monroe			May 25,	2005	2100 M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or l			4c. County of Deeth	
	4		503 S. Kaywood Dr		da lasticat de la	Salisbu		Date of Dieth	Wicomico	la a Chata as Fasaina
	Funeral		5. Social Security Number 6. S	TSTM 2□ E	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day,		ace (State or Foreign try)
	Director		579-46-8343 Usual Residence of Decedent		70 Yrs.			8/18/19:	34 West	Virginia
	land w		10a. State 10b. County		10c. City, Town or Lo	cation			1	0d. Inside City Limits
	Mary 1 eh	ŏ	Maryland Wicomic	' O	Salisbur	W				1)∑Yes 2 □ No
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	With Man	Ī	503 S. Kaywood D	r		21804			USA	
	72 hours after death with the Maryland natural", or Itema 23a or 28a-f ehow iteal Examiner must be natified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.1	Was Decedent of His f Yes, specify Cuban		ify Yes or No-	14. Race - Americ	an Indian,
10	lter o	Fun	1 🔀 Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ N	lo		, Mexican, Puerto R	ican, etc.)	Black, White,	etc.
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<u>a</u>	lid by fenta	ToE	Robert Warner Mon	roe			Rhoda	West		
Maryland	2 should be filed within 72 hours aft and Mental Hygiene. is marked other than 'natural', or aumatic event, the Medical Exami	_	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rural	Route Number,	City or Town, State, Zip	Code)
2	alth a		Carolyn Monroe-Ko	atz/niece	300	E. 93rd S	t., Apt.	30D, Nev	V York, NY	10128
ē,	f Heal		20a. Method of Disposition		20b. Place of Dispo		Da		Dc. Location - City or To	
9	age ent o et: If y or		1 St Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		Wicomico	Memorial	6/4/0)5	Salisbury,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show appring yor other traumatic event, the Medical Examinet must be notified at once.		21. Signature of Funeral Service Lice		Park	. Name and Address				
Ba	Depa Impo eny ir		YTIA 6	Inc. (CIP H	olloway F	uneral Ho	ne Profe	essional As	sociation
	eron e dass		23a. Pa 1. Enter the disease, or comp	olications to t caused	the death. Do not ent	er the mode of dying	, such as cardiac or	respiratory arres	y, MD 2180	Approximate
4			shock, or heart failure. List only Immediate Cause (Final			110.10				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		HOUD	<u> </u>			2
	Examiner			Due to (or as	a consequence of):					
1000		43	Sequentially list conditions,	b. Due to for as	a consisquence of):					
	bed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	540 10 (51 40	a contemporario org.					
	and and	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
760,	eath certificate be executed attending physician and for use as the burial-transit	alE								
687	tificate ng physi as the l			d						
9 ×	n certificate inding phys use as the	Physician/Medic	IF FEMALE:	23c. If yes, outcome	of programmy					
Вох	death o	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of delive Month	ry Day Year
	0 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				
P.0	a S	Ph	Part II. Other significant conditions c	ontributing to death h	it not reculting in the u	nderlying cause gwer	o in Part I	23e Did toha	icco use contribute to th	e cause of death?
Ś	w requires that been signed to should be det	by	Tarin. Other signmount conditions o	onthocting to death b	at not resulting in the di	nderlying dause giver	THE CITY.		2 □ No 3 □ Prob	
orc	nedui nould	Completed						1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20,140 30,100	To The Control of the
Š	aw s b	pie						24a. Was an autopsy	prior to cor	osy findings available npletion of cause of
8	The ate	Ö						performe 1 ☐ Yes 2 (ed? death?	2□ No
of Vital Records,	Phyaician: The this certificate ral director, pag	Be (25. Was case referred to medical examiper?				26. Place of Death	Check only one		
>	Phyaic this ce al dire	10	1 Ves 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatier	nt 3□ DOA Other	4 ☐ Nursing Hom	e 5 Aesiden	ce 6 Other (Specify	')
٥	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y 28b. Time of Injury	28c. Injury Work	at 28	d. Describe how	injury occurred	
.0	Attending r death. sctor: After by the funer	atic	2 ☐ Accident investigation				es 2 🗆 No			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, str	eet, factory, office	28	If. Location (Street)	eet and Number or Rura State)	Route Number,
Ö	s afte	Seri		ganamy, on	(0,000)/			,,	,	
	hour hour mera y fille	ai	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge, deat	occurred at the time	e, date and place, ar	nd due to the cau	ise(s) and manner as st	ated.
	n 24 n 24 ne Fi	Medical	(Check only 2 Medicel Examone)	and manner sta		vestigation, in my opi	nion, death occurred	at the time, dat	e and place, and due to	the cause(s)
	To the comp	ž	29b. Signature and title of certifier			29c. License	- Vern	290	d. Date signed (Month,	Day, Year)
	18		I lu Sur			450	451	5	5/27/05	
	1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type.	Print)			1/	
	100		Chris Smyder Dr	. 100 E	Carroll St.	Salisbu	y no	21801		
	Sta	te	31. Date filed (Month, Day, Year)	32. R	eath (Item 23a) (Type, Lavvo II St. ar's Signature	1 4	-			
1	Regist		MAY 3 1	ZUU5	we St. B	porte				

			For 1 = Stete Registrar	State of Maryla		artment of H <i>tificate of I</i>		Mental Hygi	iene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	unicate of t	Jeam	2. Date of Deat	g. No. 2	3. Time of Death
	Physicia /Medic		Charles Ray		r			May 22	Day 2005	10:43AM
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Death	
			159 Honeysuckle		. last birthday)	If Under 1 Year	on Bridge If Under 24 Hrs.	8. Date of Birth	Carroll	
	Funeral Director		213 10 00/1]M 2□F	84 Yrs.	Months Days	Hours Min.	April 9	,1921 Mar	place (State or Foreign intry) yland
	and and	1	Usual Residence of Decedent 10a. State 10b. County	10c. C	city, Town or Lo	cation				10d. Inside City Limits
	Mary -1 sh	tor	MD Carrol	1	Unio	n Bridge				Y☐Yes 2☐No
	h the	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	intry?
	th wit	aiD	159 Honeysuck	le Ln.		2179)1		U.S.A.	
36	72 hours after death with the Maryland neturel', or items 23a or 28a-f show iteal Examiret must be neilified at	by Funerai	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates: 194		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ Wo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	n 72 hours "neturel", edical Ex	Completed b	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	during most of work	king	16b. Kind of Business/li	
121	d within jiene. r then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		burner o	*		coment co	
d 2	Hygi Hygi ther nt, t		17. Father's Name (First, Middle, Last)		KIIII	burner	18. Mother's Nam	e (First, Middle, N	cement co	,
an	e d ital	To Be	Charles Carroll	Pittinger			Addi	e Belind	a Wantz	
ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number,	City or Town, State, Zi	p Code)
	s 1 and 2 should f Health and Men item 27 is merke other treumatic		Arneda T. Pitting						ridge, MD 2	
Baltimore,	e = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, crer	sition (Name of natory or other place. 's Luth.			Uniontown	
Balti	permit. Pag Department Importent: I any injury o		21. Sign by of Fineral Service Licens	Var Den	22	. Name and Addre	ss of Facility H	artzler	Funeral Home, MD 21791	ne
	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the de						Approximate Interval Between
Ą	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (of as a conse	welia	LINS	everen	Δ		Onset and Death
H	Examiner		Sequentially list conditions.	Congest	eue V	teerny	Parker	e e		400
	pe eq	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as conse	equence of):	· ·				7.0
	ficate be executed g physician and is the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a conse	equence of):	the IT				16ems
68760,	e be e siciar e buria	caiE		d						
		l edicai								
O. Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliving Month	very Day Year
م:	that the		Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	eacco use contribute lo	the cause of death?
gp.	uires sign ld be	d by						1 □ Ye	s 2 ØN o 3□Pro	bably 4 Unknown
ecords,	s been si	Completed						24a. Was ar	24b. Were aut	opsy findings available
	0 5 6	шо						autops perform 1 Yes 2	y prior to co ned? death? 1 ☐ Yes	ompletion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dear	th (Check only one		
of V	Physician: this certific ral director,	Tof	1 ☐ Yes 2 No	fospital: 1 Inpatient 2			4 Nursing no		nce 6 Other (Spec	ify)
		ion:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	i or Attending after death. Director: Afte I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str		.00 20.00	28f. Location (Str City or Town	reet and Number or Rui , State)	ral Route Number,
ā	itel or urs aft rel Di									
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medicai		sician: To the best of pay k ner: On the basis of exami and manner stated.						
	To the To the Comp	Ň	29b. Signature and title of certifier	// //		29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
	150) (<	1001	/	103	7949		May 23rd	12002
	W-6		30. Name and address of person who co	A A	ел 23а) Туре,	Print)	7ava	0	- DO W	N. 2457
	, ci	10	31. Date filed (Month, Day, Year)	32. Registrar's Sig		u 2he	rus he	me suit	e 201, W	refuncter
*	Sta Regist		MAY 2 5 2	1005 Marie	J.	1				

			State of Maryland / Department of Heal 1- State Registrar Certificate of Dea			ene	5 20024
	Physici	an	Decedent's Name (First, Middle, Last) John Paul Pavlovsky		2. Date of Death Month	1	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca		ridy Z.	4c. County of	Death
	Funeral Director			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, June 4,	Year)	Birthplace (State or Foreign Country)
	2	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		oune 4,	1915	10d. Inside City Limits 1 1 Yes 2 □ No
	with the M Sa or 28e-f Le pelifit	Director	Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 33 Hickory Avenue 20912		10	g. Citizen of Wh	
9	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fam az 1 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, the Marical Evantment Italian Lating once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Married 1 Never Married 2 Marr	nic Origin? (Spe lexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
00-6121	vithin 72 hou ne. han "natural e Medical E	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Court Reporter	g most of workir	ng 1	6b. Kind of Busi	
מוומ ד	d be filed vantal Hygie cad othar t cevant, th	To Be Co	17. Father's Name (First, Middle, Last) 18. M		(First, Middle, M n Magut	Legal (aiden Sumame	
Maly	nd 2 shoullith and Me 27 is mark r traumati	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N Elizabeth Pavlovsky/ Daughter 33 Hickory Avenu	Number or Rura	l Route Number,		
altillore,	rages 1 and nent of Hee nort: If itam	-	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery	June 200	4,		ring, Maryland
Dall	Departr Departr Imports any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Francis J. Co. 500 University	ollins l ty Blvd	Funeral	Home In	С
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sebic Shock	uch as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
,007	ite be executed ysician and ne burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Cardus pulmer to grant a consequence of): Cardus pulmer to grant a consequence of):	RYY	rest	-	
O. DOX 00	The law requires mat the deam certificate be executed attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3.001.000.001		23d. Date Month	,
COIDS, T.	quires that the signed by to a detach	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.			ute to the cause of death? ☐ Probably 4 🖄 Unknown
י שבני	stcian: The law requir certificate has been s irector, page 2 should	Completed			24a. Was an autopsy perform	ed? dea	ere autopsy findings available or to completion of cause of ath?
כו אונשו	this ald	To Be	examiner? 1 Yes 2 No Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4(27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	I ☐ Nursing Hon	(Check only one ne 5 🗆 Resider 28d. Describe hor	nce 6 Other	
	lo the Hospital of Attanding Priystician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	1 XI Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined (Month, Day Year) Injury Work? M 1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Str. City or Town,		or Rural Route Number,
	na Hospitë in 24 hours ha Funaral pletely filled	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, da 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	n death occurre	ed at the time da	te and place an	d due to the cause(s)
1	10 +1	Σ	29b. Signature and title of certifier 29c. License num 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA 14 AHED MO 7610 CPR 31. Date filed (Month, Day, Year) JUN 0 1 2005	mber 60100	0 29	d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA KALED MD 7610 CPR	reout,	ALE, TA	acma t	PARK, MD 20912
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 1 2005				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Lyla Elizabeth Posey 2005 May 24, 9:35A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center Plata La If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1□M 2X1F 80 577-30-8979 22,1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Charles

Nanjemoy

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. If a Madical Examinat rust be retified at once.

Physician

/Medical

Examiner

Funeral

Director

Pmysician /Medical **Examiner**

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Amed Forces? 1 Never Married 2 Married 1 Yes 2 No 1	American Indian, White, etc. Black
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. Armed Forces? 1 Never Married 2 Narried 1 Never Married 1 Never Married 2 Narried 1 Never Married 1 Never Married 2 Narried 1 Never Married 1 Never Married 1 Never Married 1 Never Narried 1 Never Married 1 Never Narried 1 Neve	White, etc.
Elementary/Secondary (0-12) College (1-4or 5+)	ness/Industry
5 12 Homemaker Her Hor	ne.
Samuel Johnson Anne Ross	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta	ate, Zip Code)
Juanita P. Taylor Daughter 4903 Rio Lane, Clinton, Md. 207	
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cit cemetery, crematory or other place) 20c. Location - Cit cemetery, crematory or other place) 20c. Location - Cit cemetery, crematory or other place) 20c. Location - Cit cemetery, crematory or other place)	y or Town, State onsides, Mo
21. Signature of Funeral Service Licenses M00668 Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian H	20640
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last b. Due to (crass consequence of): Due to (or as a consequence of):	
d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month 5 Other (specify)	
	ute to the cause of death?
autopsy prio performed? dea	re autopsy findings availab ir to completion of cause of th? Yes 20 No
v 25. Was case referred to medical 26. Place of Death (Check only one)	700
examiner? O 1 Yes 2 Data Hospital: 12 Lapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other ((Specify)
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?	
2 Accident investigation M 1 Yes 2 No 3 Suicide A Homicide See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of City or Town, State)	or Rural Route Number,
29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29b Signature and title of certifier 29c License number 29d Date signed (A	
D-45737 5/24/	05
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Nirmaladevi Jayanthan, MD 3328 Old Washington Road, Waldorf, MD 20602	
ate 31. Date filed (Month, Day, Year) 32. Paiistrar's Signature, Tar 32. Paiistrar's Signature,	

Please Type or Print in Black Indelible lnk., Ensure All Copies Are Legible.
Amend item 5 per In 8844 6-17-05 vt

		State Registrar	State of Maryland		tificate of			leg. No.)	2000
iysicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Fe Relloso Pilapi	1				2. Date of Dea Month May 28	, 2005	3. Time of Death 5:00P
kamin	er	4a. Facility Name (If not institution, give s Prince George's			4b. City, Town, o Chever	r Location of Dea $1\mathrm{y}$		4c. County of Dec	George's
neral ector		218 31 7560 	7. Age (In yrs. le	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month Day APT1		nthplace (State or Fore
No. of	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		Town or Lo	cation leights				10d. Inside City Lin
thenoul	Director	10e. Street and Number 1221 Mentor Ave	ocorge Tark		10f. Zip Code 207	43		10g. Citizen of Whal C	•
any injury or other treumetic event. If a Medical Exertinastice rutified at once.	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes XXNo If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I □ Yes 2 ¼ No	lispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: A	ite, etc.
I've Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	tent's Usual Occup kind of work done DO NOT use retired 1er	during most of wo	orking	16b. Kind of Business Educati	•
tic event	To Be (17. Father's Name (First, Middle, Last) Ferdinando Pila	oil				me (First, Middle, Relloso	Maiden Sumame)	
er treume		19a. Informant's Name/Relationship (Type Nery Constantino ((sister)	1221	Mentor A	ve, Capi	ural Route Numbe tol Heig	r, City or Town, State, hts, MD 2	Zip Code) 0743
ry or oth		20a. Method of Disposition 142 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	sinovar irom Otato	ace of Dispo emetery, cren surrect	sition (Name of natory or other pla)	wne 2, 2 metery	2005	20c. Location - City o	
any inju once.		21. Signature of Funeral Service/License	and the same of th	22	. Name and Addre	ss of Facility $L\epsilon$		l Home,Inc nton, Mary	
cian		23a. Part Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death	4	er the mode of dying	ng, such as cardia	c or respiratory are	rest,	Approximate Interval Between Onset and Deat
iner inertransit	dical Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ante.	he morn	-hage	anvuny	\$m	
d be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 □ Yes 2 □ 10 9 □ Unknown	ac. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
ld be deta	by	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute es 2 No 3 F	to the cause of death?
irector, page 2 should	Completed						24a. Was a autops perfor 1 □ Yes	sy prior to med? death?	utopsy findings availa completion of cause s 2 \(\square\) No
0	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man of Death 1 Natural 5 Pending investigation	ospital: XX Inpatient 2 D E 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing i		ne) ence 6 □Other (Spa ow injury occurred	ecify)
completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Płace of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
completely filled in by the funera	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examir	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tirvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the c urred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
com	M	29b. Signature and title of codition	3ce		29c. Licens	e number 43 G G Z	2	9d. Date signed (Mon	
		30. Name and address of person who co			-				

			For State Registrar		State o	f Marylar			ent of H ate of L			ental Hy	gien Reg. No	A	13 100		
	Physici		Decedent's Name (I			binett						2. Date of D Month		iy	Year	3. Time 0	Death M
	/Medio Examin		4a. Facility Name (If no						y, Town, or			03		Bal			~ 1
	Funeral Director		5. Social Security Num 212-24-S		Sex 1□M 2□F	7. Age (In yrs.	/ast birthday)	1-00	der 1 Year	If Under Hours		8. Date of Bi (Month, D March	th 5 1			place (Stete	or Foreign
	land ow		Usual Residence of De 10a. State 1	ecedent 0b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside C	City Limits
	e Mary lilled	ctor	MD	Car	roll		Wes	tmi	nster							1X Yes	2 No
	with th	Director	10e. Street and Number 26 Bella		t 26	ZΔ		10f. 2	Zip Code	1157			10g. C	itizen of W		ntry?	
020	riit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artenent of Health and Mental Hygene. Actionated to Health and Mental Hygene. Internet if them 27 is marked other than "natural", or items 23a or 28a-f show nitury or other traumatic avant, the Maulical Exam har must be notified at a nitury or other traumatic avant, the Maulical Exam har must be notified at a nitury or other traumatic avant, the Maulical Exam har must be notified at a niture.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 [2X Married		edent Ever in U prces? 2 No ve						cify Yes or N Rican, etc.)	0-	14. Race	- Americ White,	an Indian, etc. nite	
	filed within 72 ho Hygiene. othar than "natur ant, the Medical	Completed	15 (Specify Elementary/Seconda		ducation ade completed) College (1-4or 5+)	life. L	kind of 1 00 NOT	sual Occupa work done of use retired	durina mos	t of worki	ng	Pr	Gind of Bus Ovide fe In	nt M	iutua1	
2	t be file ntal Hy ad oth	o Be (17. Father's Name (Fin William 3			-e					er's Name .ce Bi	(First, Middle	, Maide	n Sumame)		
Mary	nd 2 should be lith and Mental 27 Is markad o r traumatic ave	ĭ	19a. Informant's Name Evelyn Rok	a/Relationship	(Type, Print)					and Numbe	er or Rura	Route Numb			tate, Zip 1157		
more,	pernit. Pages 1 and 2 Dep. rtment of Health a Important: If Itam 27 is any njury or other tra once.		20a. Method of Dispos 1 □ Burial 2 □ 1 □ Donation 5	remation 3 [State	Place of Dispo cemetery, cren arroll	natory o	r other plac	-/		†2 005		ocation - C	-		
Dallillo	permit. Departri Importa any nju		21. Signature of Fune	ral Service Lice	nsee \							e and (2115	7
	Physician /Medical		23a. Pa 1. Enter the shock, or heart for Immediate Cause (Fir disease or condition resulting in death)	ailure. List only	one cause on e	caused the dea each line.	th. Do not ente	er the m	ode of dyin	g, such as						Approxima Interval Be Onset and	te tween
	The law requires that the death certificate be executed to the law requires that the death certificate be executed to the last been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	figurantially list condition of any, leading to immicause. Enter Underly Cause (Disease or injuthat initiated events resulting in death) Las		b. Due to	cicle (or as a consec	CEFED				sho	100				24°-	30°
.O. DOX 0	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 months and 1	onths?	1 Live b	tcome of pregn birth 2 Feta nant at time of c own	al déath 3 □		pregnancy (specify)					23d. Date Mont			Year
US, T	luires that n signed by uld be deta	d by Ph	Part II. Other significa	nt conditions	contributing to d	eath but not res	sulting in the ur	nderlying	g cause give	en in Part I			tobacco Yes 2			e cause of a	
a necolus,	ilcian: The law rec certificate has bee rector, page 2 shou	Completed by	HTN									24a. Was auto perf 12 Yes		pri	ere autor or to cor ath? Yes	psy findings npletion of c	available cause of
VICAL	s certifi s certifi irector	To Be	25. Was case referred examiner? 1 Yes 2 No		Hospital:	Inpatient 2	ER/Outpatien	3 🗆	Othe	a.c		(Check only ne 5 ☐ Res		6 DOthor	(Canaih	d	
5	ing Phy Viter this		27. Manner of Death	5 Pending	28a. Date		28b. Time of Injury		28c. Injury Work	at	2	28d. Describe				<i>'</i>	
DIVISIO	To the Hospital or Attanding Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not to determined	e 28e. Place	of Injury - At hing, etc. (Speci	ome, farm, stre	eet, fact		Yes 2 🗆		8f. Location City or To	Street al	nd Number e)	or Rura	l Route Num	nber,
	ne Hospita n 24 hours na Funaral	edical C	29a. Certifier 1 (Check only 2 one)	☑ Certifying P ☐ Medicel Exa	hysician: To the miner: On the b and man	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurre estigati	ed at the timon, in my op	ne, date an pinion, dea	id place, a th occurre	and due to the	cause(s date an) and mani d place, an	ner as st d due to	ated. the cause(s	s)
	To the To the comp	Me	29b. Signature and title	e of certifier		_ \ .	. ^	2	9c. License	9 00 .	1		29d. Da	ite signed	Month, I	Day, Year)	
	K		30. Name and address	onat	completed caus	Resident //	+ Mysic	(an	7 1	881	0		5	31)	05		
	63		VIURC	a B	hat,	ND.	22	S. (reen	e St	· F	Baltin	nore	MD	2	1201	
	Sta Registr		31. Date filed (Month)	UN 0 2	2005 32. F	histrar's Signa	ature	bout	43								

1- State Registrar AMEND TIFM #5PFR FH G846 8 Gertificate of Death 1. Decedent's Name (First, Middle, Last) Physician Mont Medical Lucille Edwards Sithens 2. Date Mont Many	Reg. I	No U		
Physician /Medical Lucille Edwards Sithens May				20020
/Wedical	n [Y <i>e</i> ar	3. Time of Death
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		2005 4c. County o	f Dooth	6:50P M
Frederick Memorial Hospital Frederick		Frede		
5 Social Security Number 6 Sex 7 Ane (In vrs. last high-day) f Under 1 Year f Under 24 Hrs. 9 Date	of Rinth		9. Birthol	ace (State or Foreign
Funeral Director 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	1^{Day} ,	,1926	Alal	bama
Usual Residence of Decedent			140	
10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits 1 ☐ Yes 2 No
Maryland Frederick Union Bridge 106. Street and Number 109. Street and Number 109. Street and Number	100 /	Citizen of Wi	hat Count	
8114 Timmons Road 21791	, rog. v		nat Count	y :
Strain St	or No-	USA 14. Race		
Amed Forces? 1 Never Married 2 Married 1 Yes, 20 No If Yes, 20 No If Yes, 30 No Specify:	:-)		, White, e	
3 Wildowed 4 Divorced Year or Dates:		Specify:	White	9
To a State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Locat	16b.	. Kind of Bus	iness/Ind	ustry
To the secondary (0-12) College (1-4or 5+) Computer analyst	f	edera	1 aos	/t
O post				
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Professional Street and Number or Rural Route Market Street and Street and Number or Rural Route Market Street and Street and Number or Rural Route Market Street and				Code)
	-			
20a. Method of Disposition Date Communication Communica		Location - C	•	
All County Cremation May 25,200 1 Signature of Juneral Service Licensee 22. Name and Address of Facility Hartz 11802 Liberty Rd. Libe				
All County Cremation May 25,200 Solid Sol				21762
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.	ory arrest,		1.0	Approximate Interval Between
Immediate Cause (Final disease or condition			- 38	Onset and Death
/Medical resulting in death) Due to (or is a consequence of):				
Sequentially list conditions. b. 16X1C WEGA COLON				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence up) Cause (Disease or injury)				
that initiated events c.		-		
dical e physician at a consequence of the control o				
		1		
So of se to the past 12 months? 1	ļ	23d. Date		•
So the second of pregnancy So		Monti	n L	Day Year
Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part II 23a	Did tobacco	o use contrib	uto to the	cause of death?
0 8 58 A				bly 4 Tunknown
210 September 1919 Carrotte 1919 September 1919 Sep	Was an		ara auton	ou findings qualishin
24a.	autopsy performed?	pri de:	or to com ath?	sy findings available pletion of cause of
To the second of	es 2 N	No 1 L	Yes 2	No No
25. Was case referred to medical examiner? 1		6 □Other	(Specify)	
To be seed		jury occurred		
To be a pool of the pool of th				
27. Manner of Death 1	on (Street a r Town, Sta	and Number ate)	or Rural	Route Number,
Co site of the state of the sta				
# 6 9 # 29a Certifier 17 Certifying Physician: To the heat of my beautides death				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to an and manner stated.				
28d. Date or Injury at 28d. Date of Injury at 28d. Date or Injury at	29d. D	Date signed (Month, D	ay, Year)
29a. Certifier (Check only one) 29b. Signature and gitle of certifier 29b. Signature and gitle of certifier 29c. License number 29c. License number 29c. License number	29d. D	Date signed (—O	ay, Year)
29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the state of the sta	29d. D	Date signed (5 - 24 Fre	-0 deri	ay, Year) 5 ckmP

05-3652 B.K.S THOMAS F. SHEINALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Cer	tificate of	Death		Reg. No.		
	Dhuois	ion	1. Decedent's Name (First, Middle, Last,					2. Date of De	eath	2005	3. Time of Death
	Physic /Medi		Thomas Franklin	Sheinall Jr.				MAY	27, 2	2005 Year	0451 A
	Exami		4a. Facility Name (If not institution, give				r Location of Death			County of Death	ODGEG
			MALCOLM GROW HOSP			CAMP SI				RINCE GE	ORGES
	Funeral Director		407-30-7474	7. Age (In yrs. I	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Do Oct.	17, 1	Cour	place (State or Foreig ntry) Kas
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	/. Town or Loc	ation				1	Od. Inside City Limits
	Ba-f sho	ector	Maryland Prince (Georges Mor	ningsi						1 X Yes 2 □ No
	th with the 23a or 2	Funeral Director	10e. Street and Number 6902 Marianne Driv			10f. Zip Code 20746			_	zen of What Cour ced State	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Eventher must be notified at any once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	12. Was Decedent Ever in U. Armed Forces? 195 1 XYes 2 □ No If Yes, Give Year or Dates:		/as Decedent of H Yes, specify Cuba ☐ Yes 2 1 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Bla	etc.
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Decede	ent's Usual Occup	ation during most of worki	ng	16b. Kir	nd of Business/Inc	dustry
121	within ene. than "	шp	Elementary/Secondary (0-12)	College (1-4or 5+)		o not use retired f Engine			II C	Coast (71
	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		GIITE	I Eligine		/Fine & # # interfer			
and	f be f ntal h	Be	Thomas Franklin Sh	oinall			18. Mother's Name		, maiden	Sumame)	
Ž	should be tand Mental I	10	19a. Informant's Name/Relationship (Ty		10h M-10-	Add /Da					
Maryland	d 2 sho th and 7 is ma treum		Sheldon Sheinall	·			and Number or Rura reet, Woo				Code)
	1 and Health em 27		20a. Method of Disposition	20b. PI	lace of Dispos	ition (Name of		ate		cation - City or To	wn State
Baltimore,	Pages tment of tent: if it		1X Burial 2 □ Cremation 3 □R '4 □ Donation 5 □ Other (Specify)	emoval from State Ar	lingto	atory or other place n Nation	al 6/29		Arli	ngton, V	/A
Ba	permit. Departr Importe any inj		21. Signature of Anneral Service License	2mppan			^{ss of Facility} McG ia Ave. N				
68760,	requires that the death certificate be executed was a fine attending physician and hours be detached for use as the burial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	rence of):	theres	clerotic	_ COCO	liove	Sila	Onset and Death
89	ifficat g phy as th	Medicai									
.O. Box	that the death cert ed by the attendin detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□E	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ry Day Year
Δ.	res that signed by be deta		Part II. Other significant conditions con	tributing to death but not resu	Iting in the und	derlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to th	e cause of death?
rds	quires n sigr	d by	cirrhosis					10	Yes 2	No 3□Proba	ably 4 Unknown
Records,	as b	Completed						24a. Was autor perio		prior to con death?	osy findings available apletion of cause of
Vital	Physicien: The this certificate hiral director, page	Be (25. Was case referred to medical examiner?				26. Place of Death	1		7	
of V	Physic this ce al dire	2	1X Yes 2 □ No	at the second se	ER/Outpatient	3□ DOA Othe	er: 4 🗌 Nursing Hon	ne 5 🗆 Resid	dence 6	□Other (Specify)
n	ding P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at 2 </td <td>8d. Describe I</td> <td>now injury</td> <td>occurred</td> <td></td>	8d. Describe I	now injury	occurred	
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree		Yes 2□No	8f. Location (Street and	Number or Rural	Route Number,
ā	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the			icien: To the best of my know		occurred at the tim	ne date and place a			and manner as eta	ated
	the Ho hin 24 h the Fur mpletely	Medicai	(Check only 2 Medical Examir one)	er: On the basis of examinati and manner stated.	on and/or inve	stigation, in my or	pinion, death occurre	d at the time,	date and p	place, and due to	the cause(s)
)	111		29b. Signature and title of certifier	Block	a>	29c. License	EME		MA	signed (Month, E Y 27, 2	2005
	411		30 Name and address of person who co	mpleted cause of death (Item			n Street	Balti	nore.	Marvlar	nd 21201
	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 0 1 200	39 Registrar's Signatu	11010						
	negisti	वा	00N V I 200	Designed for	The same of the sa						

State of Maryland / Department of Health and Mental Hygiene 20030 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Minnie I. Schwab 2005 May 30, 4:45 P /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care- Silver Spring Silver Spring Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days 578-48-5896 96 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examinst must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2√ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 901 Arcola Avenue 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 □Yes 2 🗷 No 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien mportant: If Item 27 is marked other that y injery of other traumatic arrange. Upholstery Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owen F. Heater Edith Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Schwab/ Son 114 Nutmeg Lane, Winchester, VA 22602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State June 2005 permit. Page Department of Important: If any injury or Cedar Hill Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma of Ovary Physician 2 Months /Medical Due to (or as a consequence of): **Examiner** Pulmonary Metastasis 1 Month Sequentially list conditions, if any, leading to immediate cause. Life, underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit certificate be executed Peritoneal Metastasis 1 Month and physicien a s the burial-1 Due to (or as a consequence of) Box 68760, Physiclan/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy į in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 Tes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate 1 ☐ Yes 2 □ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 0 Binh M.D. 10015060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10829 Georgia Avenue, Silver Spring, Md 20902 Peter S. Binh, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Schultze May 26 2005 6:10 P^{M} George Harold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 6. Sex 1. M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. March 17 215-46-2461 105 1900 Washington, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Montgomery Kensington Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11306 Connecticut Avenue #306 20895 United States or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: β Specify: White 3X Widowed 4 □ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn important: if item 27 is marked other the any Injury or other trainmain. Automobile Owner of Auto Dealership 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adolph Schultze Anna Louise Newmann ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen S. Quinn / Daughter 9407 Elsmere Court Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 1, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery Brentwood, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home once 10 E. Deer Park Dr. Caithersburg, MD 20877 TEUGI Approximate Interval Between Onset and Death e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part1. Enter the Immediate Cause (Final Physician Congestive Heart Failure /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IE FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy 2 Fetal death Day Month Vear in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Pneumonia Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Acute Renal Failure 24a. Was an autopsy has certificate 1 ☐ Yes 2 💢 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2X No ို 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 X Natural 5 Pending Injury 1 🗌 Yes 2 🗌 No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D52261 May 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, M.D. 1517 Hugo Circle Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) Registrar's Signature Staté JUN 01 2005

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

	1 - For State Registrar			,		tificate of	lealth and N <i>Death</i>	vicinai i iy	Reg. No.	005	200	33
islan	Decedent's Name	e (First, Middle, Las	st)					2. Date of De	ath Day	Vana	3. Time of	Death
ician dical	Angel	a	Renee'	Sh	oles	5		May 27	' , 200)5 Year	3:55	P
niner			e street and number)		4b. City, Town, o	r Location of Death		4c. C	ounty of Dea	ith	
		Medical				La Plat			Ch	narles		
al	5. Social Security N	1	ex 7. A	ge (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, D	th y, Year)		nthplace (State o	r Forei
or	219-96-6 Usual Residence of	0//3	- X	25	115.			Aug. 1	7, 19		ryland	
6	10a. State	10b. County		10c. City, Tow	n or Lo	cation					10d. Inside Ci	ty Limi
to	MD	Prince (Senrae's	Ft. Wa	ashi	naton					1 🗆 Yes	2 X IN
Director	10e. Street and Nur		acorge 3	10. 110	33111	10f. Zip Code			10g. Citize	on of What C	ountry?	
0	7902 Bo	ck Rd.				20744	b		US		, .	
Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Sp	ecify Yes or No			erican Indian,	
Fu	1 💢 Never Marri	ied 2□ Married	Armed Forces' 1 ☐ Yes 2 🏋		11	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, Whi		
l by	3 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 X No	Specify:		S	pecify: W	nite	
Completed	(Spec	15. Decedent's Ed	ducation	16a.		ent's Usual Occup	ation during most of work	ding.	16b. Kind	of Business	/Industry	
J dr	Elementary/Seco		College (1-4or	5+)	life. E	OO NDT use retired	d)	arig	_			
Ö	11				Cas	hier			Bar			
Be	17. Father's Name						18. Mother's Nam		Maiden S	umame)		
10		ee Sholes						. Dent			· <u>-</u>	
		ame/Relationship (7 am - Step	** *				and Number or Run					
	20a. Method of Disp	<u>-</u>	-rather			sition (Name of	., Ft. Wa					
	1 💢 Burial 2 (Cremation 3	Removal from State	cemeter	ry, crem	atory or other plac	ce)	Date		ition - City or		
		5 Other (Specify			_	em. Gard		3-2005	Wald	orf, N	1D	
DOCE. To Be Completed by Funeral Director	21. Signature of Fu	neral Service Licen	M012	46		Name and Addres	neral Hom	ie				
		no dispase or come	olications that cause	d the death. De		P.O. Box	<u>156. Wal</u>	dorf. M	D 20	604	A	
	snock, of nea	n railure. List only	one cause on each l	ine.	iot ente	or the mode of dyln	g, such as cardiac	or respiratory a	rest,		Approximate Interval Betv Onset and D	veen
n al	<pre>tmmediate Cause (disease or conditio resulting in death)</pre>					MURIC	35				91199t di10 E	
r	,	- (Due to (or as	a consequence	of):							
er	Sequentially list con	nditions,	b. Due to (or as	a consequence	of).							
- E	cause. Enter Unde Cause (Disease or	rlying injury	200 (5 (5) 00	a consequence (51).							
Examln	that initiated events resulting in death) L		c Due to (or as	a consequence	of):							
		(-									
Physician/Medical		-	d									
N/W	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregnancy					23/	d. Date of del	iven	
cial	in the past 12	months?	1 □Live birth 4 □ Pregnant a	2 Fetal death time of death		Ectopic pregnancy Other (specify)			200	Month		ear
Jys	9 Unknown	3140	9□ Unknown									
by PI	Part II. Other signifi	icant conditions co	ontributing to death b	out not resulting in	the un	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of de	ath?
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ompleted								24a. Was	an s	24h Were au	itopsy findings a	vailal
E D								autop		prior to	completion of ca	use c
Ö	25. Was case referr	red to medical					00.51 4.5 4		2 No	Yes	2 🗆 No	
O B	examiner?		Hospital: 1 ☐ Inpatie	ent 25 ER/Out	Imations	20 DOA Othe	26. Place of Death			70th - 10		
<u> </u>	27. Manner of Death		28a. Date of Inju	iry 28b. T	ime of	28c. Injury	er: 4 ☐ Nursing Ho	me 5 ☐ Resid 28d. Describe h	ow injury o	Lotner (Spec		-7-
atlon	1 ☐Natural 2 ☐ Accident	5 Pending investigation	5-27-	y Year) Ir	ijury	Work	? ./	4			1PAG U	TIP
fica	3 ☐ Suicide	6 Could not be		ury - At home, fai			-	- 2.00,0		lumber or Ru	14	,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physici /Medic Examir

Medical Cert

pos man

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number OCME

29d. Date signed (Month, Day, Year) May 28, 2005

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street MA WALLAND

31. Date filed (Month, Day, Year)

32. Refistrar's Signature

JUN 0 1 2005

State Registrar

			1 - For Registrar	State of Maryl		artment <i>rtificate</i>			Mental H	ygien Reg. N		1 Today		
	Dharini		1. Decedent's Name (First, Middle, Last)						2. Date of I	Death	60		me pf Dea	ith3
	Physici /Medio		Redmond Herman Sellers						7, 20	ория 205 — Yea	8:	45 P	М	
	Examir	ner	4a. Facility Name (If not institution, give s	·		, ,		ation of Death	h		c. County of De	ath		
	Eumanal		3224 Empress Place 5. Social Security Number 6. Sex		yrs. last birthday)	Bryar If Under 1	s Roa	. d Under 24 Hrs.	8. Date of E	Charles				
	Funeral Director			M 2□F 71	Yrs.			ours Min.	(Month, I	Day, Year 6 • 1	933 50	irthplace (S Co <i>untry)</i> uth C	are or Fo	reign in a
	pu ,		Usual Residence of Decedent						000. 1	0, 1.	333 30	u cii c	arui	IIIa
	filed within 72 hours after death with the Maryland Hygiene. Ather then "natural", or Items 23a or 28a-1 show ant, I'le Medical Examinat must be rediffed at	'n	10a. State 10b. County		City, Town or Lo								ide City Li]Yes 2 X	
	the M	Director	Maryland Charles 10e. Street and Number		Bryans F					1			JYes 2∧∆	
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	death ms 23	Funerai	3224 Empress Place	12. Was Decedent Ever i	n U.S. 13.		516 nt of Hispan	nic Origin? (Si	pecify Yes or N		ted Sta		an	
9	after (Fur	1 Never Married 2 Married	Armed Forces? 1 M Yes 2 □ No If Yes, Give		f Yes, specif	y Cuban, M	exican, Puert	o Rican, etc.)		Black, Wh		ui,	
21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	1 ☐ Yes 2 No Specify:					Specify:	White				
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7	withir ene. than	фщ	Elementary/Secondary (0-12)	College (1-4or 5+)		lstere					Г			
9	filed Hygi other ant, L	To Be Co	17. Father's Name (First, Middle, Last)		opne	115 cere		Mother's Nan	ne (First, Midd		Furnitu	re		
Maryland	should be nd Mental marked o		Clifton Herman Sel	lers					ne Lore		,			
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (or Town, State,	Zip Code)		
	Health Health tem 27 I		Paul Sellers-son		5665	Bumpy	Oak F	Rd La	Plata.	MD 2	20646			
altimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event. It is Medical Examiner must be rediffied at		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ A	emoval from State	b. Place of Dispo cemetery, crer	sition (Name natory or oth	of er place)		B-2005		ocation - City o	r Town, Sta	ite	
Ë	Pag tment tant: jury c		' 4 □ Donation 5 □ Other (Specify)	M	etropoli			or <u>'</u> y		/	Alexand	ria.	٧A	
Ba	permit. Pages 1 an Department of Heall Important: If item 2 any injury or other once.		21. Signature of Funeral Service License	M0124	6 Hu	Name and ntt Fι Ω Roy	Address of Ineral	Facility Home Waldo	orf MD	2060	04-0156			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the decause on each line.	eath. Do not ent	er the mode	of dying, su	ch as cardiac	or respiratory	arrest,	/ 4= 0130	Appro	ximate al Betweer	,
			Immediate Cause (Final disease or condition resulting in death) a								1			
		<u>.</u>	Sequentially list conditions, b											
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
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9	tificat ng phy as th	ω .		COC)-										
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о <u>.</u>	that the de led by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions confi		rapulting in the con-	4-4		D. 41	00 - Did					
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Ö		e Completed												
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Vital	@ CL		25. Was case referred to medical					St. (5	1 ☐ Yes	2. No	1 ☐ Yes	2 ≤ No		
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ס ר	ng Phy ter thi	I iu	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time of				28d. Describe how injury occurred					_
<u> </u>	Attending it death. ector; After by the fune	atic	1 ■ Alatural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)				M 1 Yes 2 No							
-	il or Attendir after death. I Director; Af d in by the fur	Certification:					at, factory, office 28f. Location City or			on (Street and Number or Rural Route Number, Town, State)				
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	the Hin 24 the Fi	ledicai	(Check only 2 Medical Examin	er: On the basis of exam and manner stated.	ination and/or inv	estigation, in	my opinion	, death occur	red at the time,	date and	place, and due	to the cau	ise(s)	
	vithin To the compl	Σ	29b. Signature and title of certifier	Tago	uzi	29c. L	icense num	iber			e signed (Mont	•	ar)	
7	,		D-50883					5-	5-28+05					
1	21/31		30. Name and address of person who con		, , , , ,	•	ъ.							
1 6	Sta	0	Yahia M. Tagouri 31. Date filed (Month, Day, Year)	25500 32. Re gistrar's Sic	Point Lo	ookout	Rd.,	Leona	rdtown,	MD	20650			
	Registra	-	JUN 0 1 200		K A	antis								

THOMAS SHEARER

			1 - For State Registrar	State of Maryla		artment of rtificate o		d Mental Hy	/giene Reg. No 2001	20035		
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) ORVILLE ISAAC SOMERS 2. Date of Death Month Day Year May 22, 2005									
	Examir	er	4a. Facility Name (If not institution, give Peninsula Region) 5. Social Security Number 6. Se:	al Medical	Confu vrs. last birthday)	4b. City, Town	n, or Location of E SOUSOUM par If Under 24	/	4c. County of De	•		
	Funeral Director			M 2□F 82		Months Da	ys Hours 1	8. Date of B	9,1922 мл	ARYLAND		
	with the Maryland a or 28a-f show Le nyllfled at	ğI	10a. State 10b. County DELAWARE SUSSE		City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No		
	or 28	Dire	10e. Street and Number			10f. Zip Cod			10g. Citizen of What 0	Country?		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or items 23a or 28a-1 show any loury or other traumatic event; it a Medical Evacution must be notified at once.	rai	725 EAST IVY	DRIVE		199			AMERICA			
980		۵	PELAWARE SUSSE 10e. Street and Number 725 EAST IVY 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give 194		Was Decedent of Yes, specify C		? (Specify Yes or N luerto Rican, etc.)		nerican Indian, lite, etc. IHITE		
21215-0036		Completed	Elementary/Secondary (0-12) College (1-4or 5+)				ne during most of tired)	working	16b. Kind of Business/Industry MANUFACTURING			
		To Be Col	17. Father's Name (First, Middle, Last) LEONARD C.	SOMERS	MAII	NTENAN(18. Mother's	Name (First, Middle	e, Maiden Surname)	URING		
Maryland	nd 2 shou lith and M 27 is marl r traumati	_	19a. Informant's Name/Relationship (Ty	· · · · ·					per, City or Town, State,			
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 I iry or other tra		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	201	DD Place of Dispo	sition (Name of		^{Date} 30/05	20c. Location - City of			
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	Physician /Medical		23a Part 1. For as r complished, r heart failure ist only or Immediate Caus Final disease or condition resulting in death)	cation at caused the die cause on each line.				diac or respiratory a	arrest,	Approximate Interval Between Onset and Death		
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rds, P		þ	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contribute Yes 2 ØNo 3 ☐ F	to the cause of death?		
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Vital	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:				Death Check on	one			
of	or Attending Phys after death. Director: After this in by the funeral dii	tion: To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28c. In	2.00	7	asidence 6 Other (Specify) De how injury occurred				
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)				28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,		
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	To t Com	Σ	29b. Signature and title of certifier	11		29c. Lice	ense number		29d. Date signed (Month, Day, Year)			
,	18,00	,	peru	0		D	5353	5/	MAY 27	2005		
	100		30. Name and address of person who co Ly. James Te dd 31. Date filed (Month, Day, Year)				Suite	25 Sal	isburynd	2/801		
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Registrar DHMH 17 Rev 1/2001

			Please	Type or Print in					•		•		
			State of Maryland / Department of Health and Mental Hygier 1- State Registrar Certificate of Death Reg.						•	200	gr-one.		
			Registrar 1. Decedent's Name (First, Middle, La	Certificate of Death					Reg. No. 💪 🕖 1			3 71	me of Death
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	/Medic Examin		4a. Facility Name (If not institution, give		1011	4b. City, Town,	or Locati	on of Death	0 -		c. County of Dea		<u> </u>
			Yeninsula Regiona	al Medical	Carry	1 4	Mse	day			NICON	1100	
	Funeral			Sex 7. Age (In) 1 ☐ M 2 ☐ F	rs. last birthd	Months Days			8. Date of Bi (Month, D.	rth ay, Yea	9. Bir	ountry)	tate or Foreign
	Director		Usual Residence of Decedent	1	/ 113				9-21	4-15	137	"P	H
	nylanc how		10a. State 10b. County	10c.	City, Town or	Location							ide City Limits
	Be-f s	Director	PA Jauph	in	High	spire							Yes 2 No
	with the		10e. Street and Number	C) 1		10f. Zip Code	- 11			10g. C	itizen of What C	ountry?	
	ns 23	eral	206 Market	12. Was Decedent Ever in	n U.S. 1	3. Was Decedent of	34	Origin? (Spe	cify Yes or N	n-	14. Race - Amo	erican Indi	an.
0.0	or Item	Funeral	1 Never Married 2 Married		13. Was Decedent of Hispanic Origin? (Specify Yes or Ni If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, Whi		,	
<u></u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23e or 28e-f show umatic event, the Medical Examener must be notilled.	d by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No	cify:		Specify: Whitz						
Maryland 21215-0036	"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	(G	cedent's Usual Occu	during r	nost of workir	ng	16b.	Kind of Business	/Industry	
7	withlir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	in a	(ashier Wa					Jal Ma	rt	
ק ק	should be filed with nd Mental Hygiene, marked other than matic event, Livia	Be C	17. Father's Name (First, Middle, Last)			18. M	other's Name	(First, Middle	, Maide	an Surname)		
/lar	ould be Mental arked c	ToB	Hines Shaf	fer			V	elma	Rap	0			
Tar	O1 (0 00 m		19a. Informant's Name/Relationship	0 0 1	19b. M	ailing Address (Stree	t and Nu	mber or Rura	Route Numb	er, City	or Town, State.	Zip Code)	
	1 and 2 Health em 27 l		Caroline Shat	fer/Wifz	3.0 L	Market		treet	ate	- 00-		T. 0	
Baltimore,	Pages nent of Hut: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐			sposition (Name of crematory or other pla		611			Location - City or		ite
	permit, Pages Department of Important: If i eny injury or once.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		cconan	eck Cremate 22. Name and Addre					Xmore,	UH	23336
œ R	permit. Departr Importa eny inji		1 amanda 1	- Botto		Salver Fun	1	Hame	13370	huc	hst. (him	1
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	leath. Do not	enter the mode of dy						Appro	ximate al Between
	Physician		Immediate Cause (Final disease or condition			tscu o						Onset	and Death
П	/Medical Examiner		resulting in death)	Due to (or as a con:	sequence of):								
	LAGITIMIE	Examiner	Sequentially list conditions,	b. Due to (or as a con-	sequence of):	aduance off.							
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68	leath certificate b rattending physic I for use as the b	Physician/Medical	F FEMALE:										
XOR	ath ca attend for us		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of de Month	livery Day	Year	
o.	at the de by the a stached	nysk	1 Yes 2 No 9 Unknown 9 Unknown										
7	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								the caus	e of death?	
ecords,	w require been sig should b	edt	UAO 1 □ Yes							Yes :	2 No 3 Probably 4 Hinknown		
ecc	as be	Completed	HI	HTW 24a. Was an autopsy							24b. Were autopsy findings available prior to completion of cause of		
r									perfe 1 🗆 Yes	ormed?	death?	2 □ No	
Vita	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		OH		ace of Death					
0	Phys r this ral dii): To	1 Inpatient 2 H/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify,								cify)		
0	Attending P death. sctor: After t	atior											
DIVISION	er deg rector	Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) City or Town,						Street a	net and Number or Rural Route Number. State)			
5	ital or irs aft ral Di		Silver Si										
	Hosp 24 hou Fune fely fil	Medical	(Check only 2 Medical Exal	nysician: To the best of my iner: On the basis of exam	knowledge, de nination and/or	eath occurred at the ti investigation, in my	ime, date opinion,	and place, a death occurre	nd due to the d at the time,	cause(date ar	s) and manner as nd place, and due	stated. to the car	use(s)
	To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Mec									h. Day, Ye	ar)	
	- s + ō) (Sh			H	500	197		5	131/05		
	23		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Chils Snyder 100 E Cankoll 31. SACISBUTY MD 21801										
	100		31. Date filed (Month, Day, Year)	100 E CANI	7011	5%. 3	540	pour	1 111:	0	21801		
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	•	For State Registrar	State of Ma			rtificate c		- montal	Reg. i	GUUS	2003/
		1. Decedent's Name (First, Middle, Las	st)					2. Date o	f Death		3. Time of Death
nysiciar Medica	ıl -	Helen J. Smith						Month		7 200.	5 /2:10 M
xamine	r	4a. Facility Name (If not institution, give	,			47.5	n, or Location of D		1	4c. County of De	
· ·		North Arond 5. Social Security Number 6. Se			last birthday)	GIC/					Arundel
neral ector			□ M 2□NF	53	Yrs.	Months Da		Min. (Month	, Day, Yea	951	irthplace (State or Foreign Country) SC
		Usual Residence of Decedent			-				<u> </u>		
the Medical Examiner count be notified at	.	10a. State 10b. County	3 . 3		ty, Town or Lo						10d. Inside City Limits 1∑ Yes 2 ☐ No
100	Funeral Director	MD Anne Aru	nider	IVII.	llersvi	10f. Zip Cod	•		100	Citizen of What C	
Ž	5	518 Valleywood Rd.				21			109.	U.S.	
0.00	Jera	11. Marital Status	12. Was Decedent		.S. 13. \		of Hispanic Origin Juban, Mexican, P	? (Specify Yes o	r No-	14. Race - Am	nerican Indian,
با		1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ I If Yes, Give	No Ai	r ,	1 Yes, specify 0 1 ☐ Yes 2 🕱 1		uerto Rican, etc.)	Black, Wh	_
1	o D	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	For	Je					Specify: BL	
otol	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most of	working	16b.	Kind of Busines	s/Industry
E	E	Elementary/Secondary (0-12)	College (1-4or 5	5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_	selor			Medical	Caro
0	O I	17. Father's Name (First, Middle, Last)	*			COUIN		Name (First, Mic	ddle, Maid		Care
	0	Mayfield Jones					Helen	Craft			
		19a. Informant's Name/Relationship (T	•				et and Number o				
		Dominique Covingto	n/daughte		2954	West 11	th Lane		_		
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □I	Removal from State	200. P	lace of Disposemetery, cren	sition (Name of	-/1	Date	20c.	Location - City o	r Town, State
- 1											
2		* 4 □ Donation 5 □ Other (Specify,)		ergreen	n Cemete	ery 6/1	/2005		ew Haven	, CT
ouce.		21. Signature of Funeral Service Licen)		ergreer Le	Cemete Name and Ad Wis N.	ery 6/1 dress of Facility Watson B	funeral	Home		, CT
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State Registrar

Near the Arondol Hospital
31. Date filed (Month, Day, Year)

JUN 0 1 2007

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDMUND Ρ. TOMLINSON. 7,2003 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dinsula le gional Medical WILDMILD 7. Age (In yrs. 8. Date of Birth (Month, Day, AUG 6,] **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Min. 56 Director 191-38-6376 Yrs PENNSÝLVANIA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location item 27 le marked other then "natural", or Iteme 23a or 28e-f show other treumatic event, the Medical Examination mant be notified at NORTH 10d. fnside City Limits by Funeral Director ROLETTE 1X Yes 2 □ No DAKOTA ROLLA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 5TH AVE N.E. 58367 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1968-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi EDMUND P. TOMLINSON, JR. DORIS ELIZABETH BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 LYNN L. TOMLINSON / WIFE P.O. BOX 1088, ROLLA, NORTH DAKOTA 58367 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State parmit. Pages 1 Department of H Important: If ite any injury or ot once. CREMATORY OF DELMARVA 5/28/2005 `4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DELAWARE 21. Signature of Funeral Service Licensee WATSON FUNERAL HOME, INC., 211 WASHINGTON ST. MILLSBORO, DELAWARE 19966 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final **Physician** Carcogenie disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has performed? 2/2 No 2 🗆 No 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signat 29d. Date signed (Month, Day, Year) D46536 D 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) wellberg 201 Pine Bluff Ad. Suite 25, Salisbury Md 2150 32. Paistrar's Signature State MAY 3 1 2005 Registrar

DHMH 17 Rev 1/2001

donvad Tombinson

			1 - For State Registrar	State of Ma		/ Depa		of H	ealth a			jiene eg. No. 2	2005	20039
	Dharaisi		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	th Day_	Year	3. Time of Death
	Physici /Medic		Virginia Lee	Toa	dvine	>					May	29	2005	1948 M
	Examin		4a. Facility Name (If not institution, give s			,	4b. City, 1		Location of	Death			unty of Death	
			Peninsula Regional		Cent	ur	# 1 lada		Isbury	d Heal			HICOMI	
	Funeral		5. Social Security Number 6. Sex	7. Age		st birthday) Yrs.	ff Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		217–30–8946 Usual Residence of Decedent	71							4/16/19	34	Mar	yland
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mar	to	Maryland Wicomi	.co	H	lebror	ı							1 ☐ Yes 2 XNo
	death with the Maryland ims 23a or 28a-f show	Director	10e. Street and Number				10f. Zip	Code				log Citizer	of What Cou	ntry?
	23a	rai	6844 Rockawalkin R	Rd.				2183				US		
	tems frems	Funeral	THE THE SECTION	12. Was Decedent Ended Forces?		. 13.	Was Decede If Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
36	s afte	by F	1 ☐ Never Married 2½ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		1 🗆 Yes 2	No No	Specify:			Sp	ecify:whit	·e
15-0036	within 72 hours after ene. then "netural", or Ite	ed b	15. Decedent's Educ		- 1	16a. Dece	dent's Usua	I Occupa	ition				of Business/Ir	
Ċ	in 72 "na fedic	olet	(Specify only highest grade	e completed)	,	(Give	kind of wor DO NOT us	k done a e retired,	luring most	of workin	g			·
22	y with piene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	')	Teac	her					Edu	ucation	ı
פ	be filed within 72 hours after death with the Marylar at all tygiene. All tygiene. All tygiene. All the Medical Exam me must be notified at a yeart, the Medical Exam me must be notified at	Be C	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle,	Maiden Su	mame)	
<u>a</u>	uld be Mental irked tic ev	5	Claude James Holl	oway					Grac	e Tw	illey			
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty			19b. Mailin	ng Address	(Street a	ind Number	r or Rural	Route Numbe	r, City or T	own, State, Zi	p Code)
	and sealth n 27		William E. Toadvi	ne/husband					kin R	d.,	Hebron,			
ore	Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	Removal from State	Wicer	netery, crei	nsition (Name matory or of Memo.	ne of ther place	9)		ate	20c. Loca	tion - City or T	own, State
Ē	ment ment tant: jury		' 4 □Donation 5 □ Other (Specify)		1120	Park			;					Maryland
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		1 Sin atura of Funeral Service License			Ĥ	2. Name and Ollowa	d Addres ay F	s of Facility unera	1 Ho	me Prof	essio	onal As	sociation
	TO 2 8 0		23a. Part1. Enter the disease, or compli		CFSP	5	$01_{\rm Sn}$	H_{WC}	ill R	d.,	Salisbu	ry, M	ID 2180	4 Approximate
П			shock, or heart failure. List only or	ne cause on each line	me deam. e.	Do not ent	er the mode	or ayıng	g, such as c	cardiac of	respiratory an	est,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sepsis										3 days
	/Medical Examiner		Toolating in doubt,	Due to (or as a	conseque	ence of):	Inland	4011						/
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	petr Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	the me a la	remi	c 40	10110	smo	lar	NON	Ketoti	C 34	Wdo	
<u>,</u>	n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):	70.0							
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99	leath certificat attending phy I for use as th													
Box	death certifica e attending ph id for use as th	an/N	23b. was decedent pregnant	23c. If yes, autcome o			⊒Ectopic pre	egnancy				230	d. Date of deliv	
	0 0 0	sicis	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at t			Other (spe						Month	Day Year
o. O	The law requires that the de ate has been signed by the a page 2 should be detached i	Physician/Med	9 🗆 Unknown								220 Did to	haasa usa	anatributo to t	the equal of death?
Ś,	res the	þ	Part II. Other significant conditions con	ntributing to death bu	t not resur	ting in the u	nderlying ca	ause give	en in Part I.			es 2 P1	/	the cause of death? bably 4 DUnknown
o C	w require been sign should b	ted	DIGDORES									ī	2007	
Records,	has b	Completed									24a. Was a autop perfor	sy	24b. Were auto prior to co death?	opsy findings available empletion of cause of
_											1 Tes			2 □ No
Vital	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe) C		(Check only or		70	
		To I	1 Yes 2 No	28a. Date of Injury (Month, Day		R/Outpatier 28b. Time o		A	4 U Nur		ne 5 Resid			fy)
O	ding lh. After funer	tion	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury	м	8c. Injury Work 1 ☐ `	(? Yes 2□N	10				
Division of	i or Attending Phater death. Director: After the in by the funeral	fica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At hon	ne, farm, sti	reet, factory	, office		2			lumber or Rur	al Route Number,
2	al or A after after I Direc d in by	Certification:	4 Homicide	building, etc.	. (Specify)						City or Tow	n, State)		
	To the Hospital or within 24 hours afte To the Funeral Direct completely filled in I			sician: To the best o										
	in 24 he Fu	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner stat		on and/or in	vestigation,	in my op	oinion, death	n occurre	at the time, o	ate and pl	ace, and due t	to the cause(s)
	With Comp	Σ	29b. Signature and title of certifier	8					number			- 1	igned (Month,	Day, Year)
	103		H				1	100	5619	7		6/11	105	
	20		30. Name and address of person who co		ath (Item :			14	1.	11	, ,,		a 150 ·	
	10		31 Date filed (Month Day Year)	M. O.	Z/8	NENT	UN 3	T.	34.	l ishu	y me		-1801	
	Sta Regista		31. Date filed (Month, Day, Year) JUN 0 2 2	32. Rafistra	o oignall	H. A	barte	,		0	′			

			1 - State Registrar	State of Marylan	-	artment of H			giene	05	20040
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medio		ALBERT COLVI	WILLIAMS	, SR	•		JUNE	Day 1 1 2	Year 005	6:00 p M
)	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	n	4c. Cour	nty of Death)
			4216 Ridge Cres			Hurlo				ches	
	Funeral		5. Social Security Number 6. Sex 1 反	M 2 TE	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day	v, Year)	9. Birth	nplace (State or Foreign intry)
	Director		215-38-1112 Vsual Residence of Decedent	77	113.			Nov. 4	1927	Mar	yland
200	M N		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
No.	8 2	ţċ	MD Dorches	ter Hur	lock						1 ☐ Yes 2 🙀 No
d d	or 28	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	intry?
back of the Mach	238	Funeral Director	4216 Ridge Cres			21643			U.S.A		
	items let	nue	TT: Maria Glatos	Was Decedent Ever in U.: Armed Forces?	S. 13. \	Was Decedent of His f Yes, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. R	ace - Amer lack, White	
0000	5	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 反 No If Yes, Give Year or Dates:		I□Yes 2√√ No	Specify:		Spec	ify: W	hite
Ind z 1 z 1 3-0030	eture		15. Decedent's Educ	ation	16a. Deced	lent's Usual Occupa	ition	4.5	16b. Kind of	Business/li	ndustry
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aryia should	i and Mentall is marked o	၉	James Franklin 19a. Informant's Name/Relationship (Typ			q Address (Street a		Usil		m Ctata 7	in Codo)
	27 is r		Janet Y. William		1	Ridge				Same	260-050000000000000000000000000000000000
, E	Hez tem othe		20a. Method of Disposition	20b. Pi	ace of Dispo	sition (Name of		Date Pur	20c. Location		
TOUL Page	ant of ht: If i		1 🔀 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	moval from State	-	natory`or other place Chapel C		16/05	Rock	Hall	MD
	Department of Importent: If i any injury or one		21. Signature of Funeral Service Livense								L. Schaec
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			23a. Part1 Enter the disease, or complice shock, or hear failure. List only one	ations that caused the death	. Do not ente						Approximate Interval Between
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	ng ph) as th	ledi									
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	he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown		Other (specify)				Jonth	Day Year
r tag	been signed by the attending p should be detached for use as		9 ☐ Unknown Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	aderhina cause awe	on in Part I	23e Did to	hacco use co	ntribute to	the cause of death?
U. J	signe d be d	1 by	diabetes W	relitus	nung m mo u	idenying dadad gire			es 2 No		
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Veició	s cerl direct	To B	examiner?	ospital:	ER/Outpatien	t 3□ DOA Othe	r	ome 5		ther (Speci	fy)
5	ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe h	ow injury occi	urred	
	oath. or: Afr he fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		es 2□No				
NA A	irecte irecte n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S. City or Town	treet and Nur n, State)	nber or Run	al Route Number,
בַּ	urs af srel D illed i										
o the Appendix of Attending Physician. The law requires that the death cardificate	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		cien: To the best of my know er: On the basis of examinat and manner stated.							
at o	onple omple	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date sign	ned (Month,	Day, Year)
-	> 0		1/ Karging	-1X/ Malar	OMD	D0	05512	7	6/	12/0	5
	io		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, I	Print)		·			21666
	C		Margaret Malare	. M.D. 13	0 Lev	e Point	Rd St	ite 10	7 Ste	vens	ville, MD
	Sta	ite	31. Date filed (Morth Nay Yely) 2005	A2 Registrar's Sign	ure						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 27, 2005 Fong Wong May 12:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 12911 McCubbin Lane Germantown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 17, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 TF China 228-80-6081 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or pather treumatic event, If a Medical Examiner must be netitived at 1 Yes 2 No Director Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12911 McCubbin Lane 20874 USA Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Amed Polces: 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook 6 Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gin Woo Lee Mei Goon Chin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germantown, Md. 20874 Anne Wong 12911 McCubbin Lane (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 29, ₽**X**0 Metropolitan Crem. Alexandria, Va. 2005 4 Donation 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 East Deer Park Dr. Gaithersburg, Md. 20877 Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocellular Carcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cirrhosis of Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760. as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 1 Yes 2X No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🌠 Residence 6 ☐ Other (Specify) Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 9 1 ☐ Yes 2 → No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 XNatural 2 ☐ Accident 5 Pending 1 TYes 2 No investigation hours after death. Ineral Director: A the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide within 24 hours a To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier 0101234191 May 27, 2005 avan Muddasani M.D.2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$3/6 ARLW [NW BLVD + #5] . #575

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0

2005

Registrar's Signature

		1 - Stata Registrar	State of Marylai		rtificate of D	eath	Reg. N	2011:	200
nysicia	an	Decedent's Name (First, Middle, Last Carrie Mae				2	Date of Death Month	ay Year	3. Time of De
Medic xamin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death	May 5	c. County of Dea	th
		1126 Ridge Rd.			Rising	Sun		Ceci1	
neral ector		5. Social Security Number 6. S 222-16-2508	ex	-		Hours Min.	Date of Birth (Month, Day, Yea eptember	9. Bird	thplace (State or Fountry) 7 WV
H		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City L
ffied	tor	DE New Ca	stle W	ilmin	aton				1 ☐ Yes 2 f
Na no	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	ountry?
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iner:	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No		Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto Ri	ry Yes or No- can, etc.)	14. Race - Ame Black, Whit	
dical Exercises must be notified at	þ	3 ☐ Widowed 4 📆 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: W]	hite
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New Page	Be	17. Father's Name (First, Middle, Last)			18	8. Mother's Name (First, Middle, Maide	en Sumame)	
	L L		Washington				Nea1		
other traumatic		19a. Informant's Name/Relationship (7			ng Address (Street and				
- b		Jacqueline Ben 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo cemetery, crei	26 Fergu sition (Name of matory or other place)	Dat	e 20c.	Location - City or	Town, State
를 .		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			Cemetery		3,2005	Chesar	eake C
any i		W-111)		7	ndrew G	COO FIL	neral H	ome	MD
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cian		Immediate Cause (Final disease or condition	One cause on each line.	Kinson		. 20			Onset and Dea
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State of Maryland / Department of Health and Mental Hygiene 20044 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle Last) 2 Date of Death 3. Time of Death Year 6:23 **Physician** 3, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** Baltimore
If Under 1 Year | If Under 24 Hrs. Baltimore Hospitul 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days M 2□F Hours -6079 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State show other treumatic event, the Medical Examiner must be notified at 1√yes 2 No Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21215 Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 ŏ Specify þ Black 3 Widowed 4 Divorced "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be fited within and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, hast) Be Doc a. Informant's Name/Relationship (T 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) any injury or other one Barrington 3800 100. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/05 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Services Rd MD 21133 Rundallstown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiactor respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepgis Neeks disease or condition resulting in death) /Medical Due to (or s a consequence of) **Examiner** year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760 certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Diabetes Mellitu or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 💢 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျှ 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 X Natural 2 ☐ Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number S 50 Huger man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 240 Siran 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

1 - For State Registrar

			1. Decedent's Name (First, Middle, Las	ot)				2. Date of De. Month	ath Day	Year	3. Time of Dea	.th
	Physici /Medic		Boston Tyr	ous I	erry	Ad	dison	June	4 1	2005	13:40	N
	Examin		4a. Fecility Name (If not institution, give	1 1	1		or Location of Dea	ith		ty of Death		
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	Funeral Director		5. Social Security Number 241-40-6734 Usual Residence of Decedent	7. Age (In)	yrs. last birthda Yrs.	Months Day			1 Year) 29	9. Birth	place (State or Foi INC	reig
	land		10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Li	mits
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ore	00		20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, ci	position (Name of ematory or other p		Date	20c. Location	-		
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Vital Records,	w requires that been signed to should be det	Completed by	rocsilate	Car Carl	. IP			24a. Was	an 24b	. Were auto	opsy findings avail	able
Re	he lav e has age 2	dmo	103 1.100	7					osy ormed?	prior to co death?	ompletion of cause	of
ta	ysician: The is certificate hadirector, page		25. Was case referred to medical		-		26. Place of De	1 ☐ Yes eath (Check only o		1 🗌 Yes	2 140	_
>	ysicii is cer direct	To Be	examiner? 1 □ Yes 2/2 No	Hospital:	2 ER/Outpati	ent 3 DOA	Whor	Home 5 ☐ Resid		ther (Speci	fy)	
ot	g Phys ter this teral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea.		of 28c. In	jury at	28d. Describe	how injury occu	ırred		
Sior	ttendin death. ctor: Afr y the fur	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	1	.,,,		☐Yes 2☐No					
Division	r Att	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, :	street, factory, offic	е	28f. Location (S City or Tox		nber or Run	al Route Number,	
	ital o											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	(Check only 2 Medical Exam	ysician: To the best of my niner: On the basis of exam								
	thin 2 thin 2 the mple	Med	29b. Signature and title of cedifie	and manner stated.		29c. Lice	nse number		29d. Date sign	ned (Month.	Dav. Year)	
h i	T W T S		Huntan				000	_			,2005	
	1.1		30. Name and address of person who	completed cause of docth	(Item 23a) /T		0 11			1	, 0 000	
	201		Good Same it	n Hospital	5601	Loch Rai	in Bivd	Balhin	ore his	112 =	39	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's S					-1 -0	4		
	Registr		HIN 1 6 200	15 6	to A.	2 K 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

			1 _ State	•	ment of Health and	•	7/11/15	20046
			Registrar 1. Decedent's Name (First, Middle, Last)	- Oerun	icate of Death	2. Date of De	ath Day Year	3. Time of Death
	Physici /Medi		Margaret BISI	VOP		June	13 200	
	Examir	ier_	4a. Facility Name (If not institution, give street and number) Stella Maris	4	o. City, Town, or Location of D		4c. County of Dear	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	M	imonium MD Under 1 Year If Under 24 I onths Days Hours N	Hrs. 8. Date of Bin (Month, Da		thplace (State or Foreign buntry)
	Director		215-12-8779	82 Yrs.		3/3/19		
	aryland show	_		ity, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the Ma 28a-f	ecto	MD Baltimore Re	isterst	OWN 10f. Zip Code		10g. Citizen of What Co	
	3a or	al Dir	6 Bridle Court		21136		U.S.A.	
	r death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	Decedent of Hispanic Origin's, specify Cuban, Mexican, Pi	(Specify Yes or No Jerto Rican, etc.)	14. Race - Ame Black, Whit	
36	urs afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	10	Yes 2 No Specify:		Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or tlems 23a or 28a-f show then "neturel", or tlems 21a the multiple at the	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent	t's Usual Occupation d of work done during most of NOT use retired)	working	16b. Kind of Business	/Industry
121	within lene. then	duc	Elementary/Secondary (0-12) College (1-4or 5+)	Homem			Own Home	
5	be filed ital Hygi id other event, I	BeC	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle,		
Maryland	should band Menti	To T	John Huemmer 19a. Informant's Name/Relationship (Type, Print)	405 Mailian 4		nette St		7:- Cadal
≥	and 2 sh ealth and n 27 Is n		Michael Bishop/son		ddress (Street and Number of dle Court		town, MD	21136
				Place of Disposition		Date	20c. Location - City or	
:10 A.M	tment of trant: If it ijury or o		`4 ☐Donation 5 ☐ Other (Specify)				Baltimore	
6:1	permit. Departr Imports eny inji		21. Signature d Funorel Seurce Li Ansee		ame and Address of Facility Chesaco Ave.		sedale Fune re, MD 212	
			23a. Part T. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Breast	Cancer	3	months
	Examiner		Due to (or as a consections	quence or):				
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):				
V	be executed sician and burial-transit	Examiner	that initiated events c	quence of):				
005 8760	the the	ical	d					
3, 2	certific rding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregn.	ancy			23d. Date of de	livery
7 0	death	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9☐ Unknown		topic pregnancy ther (specify)		Month	Day Year
JUNE	. = > %		9 Unknown Part II. Other significant conditions contributing to death but not res	sulting in the unde	riving cause given in Part I.	23a. Did t	obacco use contribute to	o the cause of death?
Ę	requires sen sign	ed by				1 🗆	Yes 2 No 3 □ Pi	obably 4 Unknown
BISHOP J	2 a a	Completed				24a. Was	psy prior to	utopsy findings available completion of cause of
BIS	Th Th page		OS Was and a modern		00.81	1 ☐ Yes	ormed? death? 2 No 1 ☐ Yes	2 No
ET B.	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient	Other	Death <i>(Check only o</i> g Home 5 ☐ Resi	one) dence 6 □Other (Spe	cify)
MARGARET			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
MARG	Attending r death. actor: Afte oy the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At h	nome, farm, street,	M 1 ☐ Yes 2 ☐ No factory, office	28f. Location (Street and Number or Ri	ural Route Number,
į	rs after rel Dire	Certi	4 Homicide determined building, etc. (Speci	<i>ity)</i>		City or To	wn, State)	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	edical	29a. Certifier 1 Certifying Physician: To the best of my known (Check only one) 1 Certifying Physician: To the best of my known one) 1 Certifying Physician: To the best of my known one of the companies of the					
	To the within 2 To the comple	Me	29b. Signature and title of certifier	14 . 5	29c. License number		29d. Date signed (Mont	
	1		Prostine Whight	- MD	D 52 74	-0	June 13	3th 2005
	4		30. Name and address of person who completed cause of death (Itel ERNESTINE WRIGHT, M.D. 2300 1			'IMONIUM,	MD 21093	
		ate			froste			
	Regist	rar	JUN 1 6 1005 A	CHELLE D				

ī			For State Registrar	State of M	aryland /		rtment of F	lealth and I Death		giene	5 20047
П	Physici		Decedent's Name (First, Middle,						2. Date of Dea	Day Y	3. Time of Death
	/Medic	al .	Steven M. Bud 4a. Facility Name (If not institution,	eysky give street and number,)		4b. City, Town, o	r Location of Death	May 19	9, 2005 4c. County of	1:40 P M
	Funeral Director		356-86-9744		mile 1 ge (In yrs. last b 27		Odent If Under 1 Year Months Days	ON If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jan. 22	th 9	Arundel Birthplace (State or Foreign Country) Russia
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Mary med	tor	Texas Bexar		Lack	land					1)(∑Yes 2 □ No
	h with the 23a or 284	Funeral Director	10e. Street and Number A. Co 314th MIBN	ı			10f. Zip Code 782	43		10g. Citizen of What	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show ship rights or other traumatic event, in Medical Examinant must be notified at once.	þ	11. Marital Status 1 Wever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' d In Test 2 In Test 3 In Test 4 In Test 4 In Test 5 In	?		Was Decedent of F f Yes, specify Cuba I ☐ Yes 2☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
5-0	72 hc "natur	Completed	15. Decedent's (Specify only highest		16	a. Deced	dent's Usual Occup	ation during most of wor d)	rking	16b. Kind of Busin	ness/Industry
121	within ene. than	дшс	Elementary/Secondary (0-12)	College (1-4or		Sold:		2)		Militar	v
od 2	e filed Il Hygi othar vant, I	Be C	17. Father's Name (First, Middle, L	-		JOI U	101	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	1
Maryland	Menta Menta arked atic ev	To B	Mark Budeysky						Maryasi		
Mar	12 sho h and 7 Is mu		19a. Informant's Name/Relationsh				,			er, City or Town, St	
e,	1 and Healtl tam 27		Mark Budeysky / 20a. Method of Disposition	Father	20b. Place	of Dispo	sition (Name of	unk!		inois 600 20c. Location - Ci	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", Important: or other traumatic event, the Medical Examone.		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	ecity)	cemet		natory or other place		1- Ti	Stokić eral Home	
Bal	Deparmi Impol	1	21. Signature of Funeral Service L	n Bors	/						y1and 20707
	Pnysician /Medical Examiner		23a. Part1. Entey the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	od the death. Do line. Lulting s a consequence	not ent		ng, such as cardiac			Approximate Interval Between Onset and Death
, 'o	executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence						
68760,	ficate be physicia s the bur	edicai		d							
. Box	death certii e attending id for use a	Physiclan/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnanc Other (specify)	y	P.ST.F.	23d. Date of Month	
ds, P.O	Se de	by	Part II. Other significant condition	is contributing to death	but not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did t	11	ute to the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed			_				24a. Was autop perio 1 Xyes	osv prio	ore autopsy findings available or to completion of cause of the cause
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			- 25 DOA 0#		ath (Check only o		
of	ng Phys fter this neral di	ation; To	27. Manner of Death 1 Natural 2 Accident	28a. Date of Ini (Month, D	ury 28b ay Year)	Time of	f 28c. Inju	4 Nursing F	28d. Describe	how injury occurred	while sitting
Division	To the Hospital or Attendir within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Certification;	3 Suicide 6 □ Could n 4 □ Homicide determi	ned 286. Place of it	njury - At home, etc. (Specify) I road		reet, factory, office		City or To	wn, State) Anut	or Aural Route Number, ack Mainlini +3 alenton, 40
	Hospi 24 hou Funar	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 X Medical E	Physician: To the best examiner: On the basis and manners	of examination a	ge, deat and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	within To the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (Month, Day, Year)
	.141		30. Name and address of person v	Halla i	C Md	(Type.		CME		May 20, 2	2005
_	H1		CHROL	HAUA	NMO	1		enn Stree	et Balti	more Mary	land 21201
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signature	1				y	TOTAL STATE
DH	IMH 17 Rev 1/2	-200	JUN 1 6 2	005 Keen	J.	apa	NEL .				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 9th 5-40P **Physician** BROWN UNE 2005 CILLIAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year)
Sep. 23, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 78 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 1926 Maryland Director 216-22-4837 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic avant, Ita Madical Examinar traumat be netified at 1 ☐ Yes 2 No Baltimore Highlands Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21227 United States 2704 Norfen Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be 2 shoutd be fi and Mental H is marked of Lillian Doerr Wallace Francis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or othar traum once. Clyde Sloan - Companion 2907 Norfen Road, Baltimore Highlands, MD 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Mearica Crayer or other place)
Memorial Park 1 Burial 2 Cremation 3 Removal from State 6-13-2005 Elkridge, MD * 4 □Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician SEPTIC Shock -4 day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MRSA BACTERIMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit 7 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, SRD Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ← ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica Be 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 0 28c. Injury at Work? funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28b. Time of Certification: 27. Manper of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Spuple MD D0053150 SUIME110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUPTA 9650 SANTIAGORDAD COLUMBIAZIOUS SHALLON MALA 32. Figistrar's Signature JUN 1 6 2005 State Registrar

Hopkins Bay	Prestreet and number) Sex 1. Age (In y 68 10c. 10c. Prestreet and number) 12. Was Decedent Ever in Armed Forces: Armed Forces: Armed Forces: Education and completed) College (1-4or 5+)	vrs. last birthday) Yrs. City, Town or Loundalk In U.S. 13.	Baltimore If Under 1 Year Months Days Docation 10f. Zip Code 2122 Was Decedent of Hill If Yes, specify Cuba 1 Yes XIX No	Hours Min. April	Day, Year 200 4c. County of De n/a Birth Day, Year) 11, 1937 Ma 10g. Citizen of What C USA No- 14. Race- An Black, Wh	inthplace (State or Foreign Country) 1 Ty Land 10d. Inside City Limits 1 Yes 2 No Country?
Hopkins Bay ity Number ity Number ity Number ity No. County Baltimore ity Number ity Baltimore ity Number ity Baltimore ity Number ity Baltimore ity Married ity Specify only highest gr Secondary (0-12) 10 ity Baltimore ity Bal	Pyview Sex 7. Age (In y 68 10c. Du 12. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates: Education ade completed) College (1-4or 5+)	Yrs. City, Town or Loandalk In U.S. 13. 16a. Deceroife.	Baltimore If Under 1 Year Months Days Docation 10f. Zip Code 2122 Was Decedent of Hilf Yes, specify Cuba 1 Yes XIX No	e City If Under 24 Hrs. Hours Min. April 2 ispanic Origin? (Specify Yes or in, Mexican, Puerio Rican, etc.)	n/a Birth Day, Year) 9. B (1) 11, 1937 Ma 10g. Citizen of What C USA No- 14. Race - Arr Black, Wh	inthplace (State or Foreign Country) 1 Ty Land 10d. Inside City Limits 1 No Country?
ity Number of S. Synchrology only highest gr Secondary (0-12) 10 ame (First, Mandele, Last and G. Gaw	Sex 1 7. Age (In y 68 10c. e 10c. e 12. Was Decedent Ever in Armed Forces? 1 Yes 212 No If Yes, Give Year or Dates: Education rade completed) College (1-4or 5+)	Yrs. City, Town or Loandalk In U.S. 13. 16a. Deceroife.	If Under 1 Year Months Days Docation 10f. Zip Code 2122 Was Decedent of Hilf Yes, specify Cuba 1 Yes XIX No	If Under 24 Hrs. 8. Date of (Month, April) 2 Ispanic Origin? (Specify Yes or in, Mexican, Puerlo Rican, etc.)	Birth Day, Year) 9. 8 7 11, 1937 Ma 10g. Citizen of What C USA No- 14. Race - An Black, Wh	aryland 10d. Inside City Limits 1 1 Yes 2 No Country?
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ndalk Ave. tus Mamied ¾™ Married ed 4 □ Divorced 15. Decedent's E Specify only highest gr Secondary (0-12) 10 ame (First, Middle, Last rd G. Gaw I's Name/Relationship	12. Was Decedent Ever in Armed Forces? 1 Yes 2\text{2X} No If Yes, Give Year or Dates: Education ade completed) College (1-4or 5+)	16a. Dece (Give	2122 Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes ※※ No	ispanic Origin? (Specify Yes or in, Mexican, Puerto Rican, etc.)	USA No- 14. Race - Am Black, Wh	nerican Indian,
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10 ame (First, Middle, Last and G. Gaw and G. Gaw and G. Same/Relationship				during most of working	16b. Kind of Busines	s/Industry
rd G. Gaw	t)			7)	Home	
				18. Mother's Name (First, Midde Ethel A. Cooke	dle, Maiden Surname)	
n A. Brook	(Type, Print)	19b. Maili	ing Address (Street	and Number or Rural Route Nur	mber, City or Town, State,	, Zip Code)
				Ave. Dundalk, N		
f Disposition 2XXCremation 3 [tion 5 □ Other (Speci	Removal from State B	Loudon	e Cremato: Park	2005	Baltimore,	Maryland
of Funeral Service Lice	ensee	22	2. Name and Addres	ss of Facility Loudon Pa 3620 Wilk	ark Funeral Kens Avenue	Home
nter the disease, or con	nolication, that caused the d	death. Do not en	iter the mode of dvin	Baltimore g, such as cardiac or respirator	cens Avenue , Maryland	21229 Approximate
r heart failure. List only use (Final ndition ath)	y one cause on each line. a. My O Cord Due to (or as a con	lial int	farction			Interval Between Onset and Death Immedia
st conditions, to immediate Underlying so or injury vents ath) Last	b. Due to (or as a con Due to (or as a con					
edent pregnant st 12 months? 2 No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of d Month	delivery Day Year
significant conditions be 4cs	contributing to death but not	t resulting in the u	underlying cause giv		id tobacco use contribute □ Yes 2 ☑ No 3 □ I	to the cause of death? Probably 4 □Unknow
				pe 1 ☐ Ye	utopsy prior to enformed? death? s 2 ☑ No 1 ☐ Ye	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
referred to medical 2 No	Hospital:	2 PR/Outpatie	ent 3 DOA Oth	er: 4 Nursing Home 5 R		necity)
Death al 5 Pending ent investigation		28b. Time o Injury	of 28c. Injun Wor	y at 28d. Describ		,,
	A 289. Place of injury - A	At home, farm, st	treet, factory, office			Rural Route Number,
1 Certifying P	Physician: To the best of my aminer: On the basis of examand manner stated.	knowledge, deat mination and/or in	th occurred at the tin	ne, date and place, and due to t pinion, death occurred at the tim	he cause(s) and manner ne, date and place, and di	as stated. ue to the cause(s)
My 2 Medical Exa	leer		142	222	29d. Date signed (Mod	nth, Day, Year)
e and title of certifier	o completed cause of death i	(Item 23a) (Type,	, Print)	offense un	21222	
	Death 5 Pending investigate 6 Could not determine 1 Certifying F	Death I Inpatient 28a. Date of Injury (Month, Day Yea investigation be determined 28e. Place of Injury building, etc. (S) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated. and title of certifiers address of person who completed cause of death	Death S Pending investigation 28e. Place of Injury At home, farm, si building, etc. (Specify)	Death Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 Yes 2 No 28b. Place of Injury At home, farm, street, factory, office 28f. Location 28c. Injury at Work? 1 Yes 2 No 28c. Injury at North at Yes 2 No 28c. Injury at North? 2 North at Yes 2 North at Ye	2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DoA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Death Street Injury 28b. Time of Injury 28b. Time of Injury Month, Day Year) 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 No 28c. Injury at Work? 2 No 28c. Injury at North Nor

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	Physici		Helena May Bohle		Month D	ay Year 7 25 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
	Examin	Ų.	1011 Genine Drive	Glen Burnie, MD		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)
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	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	acation		10d. Inside City Limits
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	he N	Director	10e. Street and Number	10f. Zip Code	100.0	Citizen of What Country?
	ath with the Marylar 23e or 28a-f show		1011 Genine Drive	21060		U.S.A.
	ns 23	erai				14. Race - American Indian,
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21215-0036	of within 72 hours after death with the Maryland sign. Jiens. Than "natural", or Items 23e or 28e-f show the Marical Examitive Francisco.	Completed		edent's Usual Decupation re kind of work done during most of worki	16b.	Kind of Business/Industry
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pu	d fall	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	an Sumame)
∑ Z	should be filed ind Mental Hygi is marked other umatic avant, I	은	Howard Thompson		immerman	T 011 T 0 11
Maryland		r i	19a. Informant's Name/Relationship (Type, Print) 19b. Ma Ms. Lillian L. Metzler / sister 1011	ling Address (Street and Number or Rura		
	l an Heath	1 3	20a Method of Disposition 20b. Place of Dis	position (Name of		Location - City or Town, State
Baltimore,	permit. Pages: Department of h Important: If Ite any injury or ot	1	1 X Hurial 2 Cremation 3 Hemoval from State	ematory or other place) June ven Mem. Park 2005		n Burnio MD
=	artme artme ortan injury	1		22. Name and Address of Facility Si		n Burnie, MD
Ba	permit. Departr Importu any inj			Second Avenue S.W		
	1111		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions			
7	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	E E	Due to (or as a consequence or).			
87	physic the	dicai	d			
9 xo	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Bo	atter 1 for u	Physician/Me		☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
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<u>ر</u>	res that igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
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ecords,	aw re	piet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Division	lor At after o Dirac I in by	Certification:	4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, Sta	and Number or Rural Route Number, te)
	Hospital or Attending 24 hours after death. Funaral Diractor: Afte tely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place :	and due to the cause(s) and manner as stated
	To the Hospita within 24 hours To the Funaral completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or one)	investigation, in my opinion, death occurr	ed at the time, date at	nd place, and due to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funaral Diractor: completely filled in by the	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
			> /My mo	750108		6 14 2005
	1		30. Name and address of person who completed cause of death (Item 23a) (Typ		-	
	V		Michael Downing 7845 Ochwood	hour Suite 200 6	un Burnie	19012 OM
	Sta	_	31. Date filed (Month, Day, Year) 32. Digistrar's Signature	lack &		
	Regist	dl	JUN 1 6 2005 Brown &			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Buegess 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rock Glen Nursing and Rellab: Inata Cen Center Baltimon MP If Under 24 Hrs. 8. Date of Birth Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Days Director Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23e or 28e-f show the Medical Exerciper roughly at 1 Yes 2 No Itimore Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U 13. Was Decedent of Vas Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 Never Married 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marked other than OMESTIC Pri 0 7 is marked other treumatic event, 17. Father's Name (First, Middle, Lest) Cornish Warner da ပ္ pher 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (5:5+er) Department of Health a Important: If item 27 is ony injury or other tree 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayto, Moa1229 202 Dorothu 20a. Method of Disposition

1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 6 18 05 4 ☐ Donation 5 ☐ Other (Specify) Joseph L. Russ Fineral Home P.A. 21. Signature of Funeral Service Line ee Bayto, MO 2/2/4 Approximate Interval Between Onset and Death North 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed the bunal-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? director, page 2 should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown ģ 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed After this certificate has 2 1 No 1 ☐ Yes 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No nours efter death.
nerel Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

29c. License number

Frederick Rd. Cofordiscle, My

29d. Date signed (Month, Dey, Yeer)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)

1009,

32. Registrer's ignature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. JET State of Maryland / Department of Health and Mental Hygiene 25tate Unpend Registrar 23a,pt.II,27 per me G844 6-17-05 fas Certificate of Death Reg. No. 05-03515 Ernest A. Buck 1-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician May 21 12:25 Рм Ernest A. Buck /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Thames and Wolfe Streets If Under 1 Year If Under 24 Hrs. 5. Social Security Numbellnk 6. Sex 8. Date of Birth (Month, Day, Year) June 21, 1947 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days Hours 1፟⊠M 2□F Months Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show other treumatic event, the Medical Examinar must be nutified at 1√ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 419 Bonsal Street Items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) unk unk disabled none other 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I snt: If item 27 Is marked o Ernest A. Buck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1827 Marshall Road Dundalk MD Glenda Koltao/frmr sister in law 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition jo = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. `4 □Donation 5 XOther (Specify) in state Ronald S. Waden Director State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of). Examiner g physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Dunknown Completed Chronic Alcohol Abuse 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No certificate has page 2 Yes 2 🗌 No Division of Vital 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) Scene 70 1 XYes 2 □ No 2 ER/Outpatient 3 DOA ihis 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospitel or Attending 5 Pending 1 ☐ Yes 2 ☐ No death, investigation 2 Accident To the Hospitel or Attence within 24 hours after death To the Funerel Dirsctor: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME May 22 2005 Tame 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southail, MI) E. 111 Penn Street Baltimore, Maryland 21201 Pamela

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 6 2005

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 12, BERMAN 2005 6:15 SHEILA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth OCT.5, 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🔽 F MD 231-54-1503 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, its Medical Examinar must be notified at 1 ☐ Yes 2 No Director PALM BEACH BOYNTON BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7264 WHITFIELD AVENUE 33437 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Serman, Sheila Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOLD NETTIE ASHMAN J0SEPH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7264 WHITFIELD AVENUE - BOYNTON BEACH, FL 33437 MELVIN BERMAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH BETH ISRAEL 6/15/2005 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multiple Immediate Cause (Final Physician montes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 000 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other. 4 Nursing Home 5 Residence 6 Other (Specify) NOSPIC 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier JUNE 13 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physion Charles, NO 6601 N. Charles St Towson to 2, 204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JUN 16** Stew & frank Registrar DHMH 17 Rev 1/2001

ORIGINAL

VERNICOLETTE CHASE Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpend item/23a,27,26a-f, pend (34),7/70 IT State of Maryland / Department of Health and Mental Hygiene All Copies Are Legible. 05-04016 **RKD** 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 12, Chase 2005 Physician ernicolet 2:21A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL NIA BALTIMORE If Under 1 Year | If Under 24 Hrs. 8.
Months | Days | Hours | Min. } 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Pay, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗷 F 39 Yrs 220-98-9854 Director lune 16 1965 Maryland Usual Residence of Decedent the Maryland Worls 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f shot other traumatic event, the Medical Examiliar must be notified at 1 Yes 2 No Baltimorp Director NIA mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ¥ith 21223 2422 W. Baltimore USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never worked permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, 9002e. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Chase evin Elva Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) alal Braddish Ave. Balto. mo 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4 Donation Park 6-18-05 King Memorial Randallstown, Funeral Service License CORN P. MURCH FUNERAL HOME P. A. 239 21. Signatur by We disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, neart failure. List only one cause on each line. Approximate Interval Between Onset and Death ause (Final Immediate Cause (F disease or condition resulting in death) **Physician** Methadone Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ ¥es 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has performed: 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 📉 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 □ No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury FILL Month, Day Year) 1 Natural 5 Pending death. 6/12/2005 12:00 A M 1 Yes 2 No 2 Accident investigation Director: / unk 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2422 W. Baltinoce St 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Baltimore, MD found at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME marie JUNE 12, 2005 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 ARGARITA KORELL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2005 Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 12:55A^M JUNE 14 2005 FRANCES CLARK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MANOR CARE - RUXTON TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 2XF 9-18-1919 Director 147-12-7202 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City, Town or Location 28e-f ahow other traumatic evant, the Medical Evantual must be notified at XYes 2 No Director TOWSON MDBALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21204 USA itams 23a 30 MALIBU CT. Funeral 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Sant: If itam 27 Is marked othar than "natural", or ital 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3√ Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLANCHE LYONS JOSEPH BLAIR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30 MALIBU CT. TOWSON, MARYLAND JEROME CLARK/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it eny injury or o 1 X Burial 2 Cremation 3 X Removal from State HILLCREST MEM. PARK 6-20-2005 HURFFVILLE, NJ * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA-Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. East underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit ro tha Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for L Month Dav in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Thomicide within 24 hours are
To the Funeral Dir 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NER E. 1220 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar JUN 1 6 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 7, **Physician** 2005 2:15 AM M Egbert A. Crispens /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 8000 Dogwood Road Lot 6 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1♥M 2□F Maryland 84 Yrs. Director 218-07-1817 Usual Residence of Decedent 10d. Inside City Limits hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Dundalk Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2913 Dunmurry Road #A 21222 USA 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 1√2 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: white 139-45 δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tra Me Elementary/Secondary (0-12) College (1-4or 5+) 10 0 welder western electric 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John William Crispens Louise Eugenia Richter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8000 Dogwood Road Lot 6 Baltimore, MD Elizabeth Crispens/spouse 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 □ Other (Specify) 21. Signature Funeral Sarvice icensee Rone Id S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition CANCER Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physicien for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 Other (specify) ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Division of Vital Records, 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No the Hospitel or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: After 5 Pending investigation 1 Natural n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 29d Date signed (Month, Day, Year) 29b Signature and title of certifier ٥ 31076 Therson who completed cause of death (Item 23a) (Type, Print) (6/18) (186-28) Bit M. AMSO, 21237

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

JUN 1 6 2005

2. Registrar's Signature

		_	For = State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			ene	05	20057
			Decedent's Name (First, Middle, Last)					2 Date of Death	1	V	3. Time of Death
	Physicia /Medic		Ernesteen Drak	e				JUNE Month	Day 14	Year 2005	1.00 AM
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	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday, Q∩ Yrs.	Months Days		8. Date of Birth (Month, Day,		Coun	
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	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10	0d. Inside City Limits
	Many -fsh	ţ	Maryland Anne Aru	ndel		Glen	Burnie				1 ☐ Yes 2 X No
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	r dea	Funerai	T. Mariar Otatos	2. Was Decedent Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
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<u>×</u>	ould to Ment arked	ပ	William Lee Tul				Mary Uni				
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9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Ever strates are		Velma Marie Dearth/ 20a. Method of Disposition	daughter	20b. Place of Disp	Washing	ton Square	Glen 2	Oc. Location	City or To	21061 wn, State
Baltimore, Maryland 21215-0036	Pages nent of I ont: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cre	amatory or other pi	Inc. 6/15		Baltimo		
들	sit. Paratme		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer I Service Licenses 	ha Orani	and the same of th						AD .
Ba	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trai once.		Design Will Call	opatd	ck S	remation 299 Frede	°Society o	ot Maryla Baltimo	and, In	C.	20
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Вох	eath certific attending p for use as	D/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome		□Ectopic pregnand	21			te of delive	*
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12AKE Division	l or Attending I after death. Director: After I in by the funer	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, farm, s lc. (Specify)	treet, factory, office	•	28f. Location (Sti City or Town	eet and Numb State)	er or Rura	l Route Number,
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	Regist		JUN 1 6 2005	The week	rar's Signature	ME					

State of Maryland / Department of Health and Mental Hygiene 20058 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JINE 12, 2005 DVOSYA DYNINA 4:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) RUSSIA 5. Social Security Number 8. Date of Birth MAR. 26, 1922 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 ☐ M 2 🙀 F 83 214-49-7062 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiena. Int: If itam 27 is marked other than "natural", or Items 23a or 28e-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be nutified at 1 ∑Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3601 FORDS LANE #209 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUBENOV DAVID FRADA **GUTEVICH** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STONEMARK COURT #7 - OWINGS MILLS, MD 21117 TSIVA ZERNOVA / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ARLINGTON CHIZUK AMUNO 6/15/2005 BALTIMORE, MD ¹ 4 □ Donation 5 □ Other (Specify) Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 3a. Part 1. Enter the disease, or complication shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cral-Vas Cular Accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown (signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🕏 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I tiretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd # 206 Bolfinere. A. PO KOL Reisterstow 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Jacqueline

4a. Facility Name (If not institution, give street and number) ger JUNE 14 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🔭 Usual Residence of Decedent Director June 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ent: If item 27 is marked to the then "natural; or Items 23a or 28a-f ahow ury or other treumatic event, Ital Mealcal Examination mat be notified at 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 21136 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 □ Yes 2.2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WFR 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be erbert orothi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paisters town Date 20c. Location City or Town, State 20a. Method of Disposition mD a1136 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F Importent: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory 6-20-05 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Jun 11, Service License Mid-Valley Dr. Jessip 1232 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or lear failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but npt resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed ² 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 12 No 1 ☐ Yes the Hospital or Attending Physiclen: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ✓ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funerel Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

30. Name and address of person who d

JUN 1 6 2005

31. Date filod (Month, Day, Year)

6701 N. Charles 80.

ause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physici		RUDOLPH FORSY	HE JR				Month JUNE	Day Year 14 2005	7.03D M
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Ball	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service License	90	VA	2. Name and Add	GREENE F	ILLEOAL S	EDVICE:	
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P.0	at the de by the a	Physiclan/M	9 Unknown	9 Unknown						
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ita	ifcian: Th	Be C	25. Was case referred to medical examiner?				26. Place of De	ath Check onl o	1	22.10
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	Funeral Director		5. Social Security Number 6. Sex 216-36-3400 Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bin 1940	hplace (State or Foreign buntry) MD
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S C	1 and Health em 27 ther ti		RAY ALLEN FLOREN 20a. Method of Disposition	20b. P	lace of Dispo	NORMOUN		Date BALTO	. MD 213 20c. Location - City or	
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_	6		July TC	Jun)		1)4	054		0/8/05	
3			30. Name and address of person who com	ipleted cause of death (Iten	23a) (Type,	fitt &	tue Br	Altro	4204	
	Sta		31. Date filed (Month, Day, Year)	professed cause of death (Item 32. Registry's Signal 2005	iture	freels)			-	
	Registi	ar	ANK TO	LUUS T REFERE	1 15	No.				

JET 05-03937 Antonio Fox

ni	o Fox		1 - For State Registrar	State of I	Maryland / D	epartm <i>Certific</i>	ent of Fate of	lealth and <i>Death</i>	Mental H	ygiene	005	20062	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time										
	Physici /Medi		Antonio Fox										
	Examir		4a. Facility Name (If not institution	n, give street and numb	er)	4b.	City, Town, o	r Location of Dea		4c. C	ounty of Death	5:23 P ^M	
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	Funeral Director	ž.	5. Social Security Number 216-08-3482	6. Sex 1 XM 2 ☐ F	Age (In yrs. last birt	Mon	ths Days	if Under 24 Hr Hours Mir		lirth Day, Year) -85	9. Birth Coul MD	place (State or Foreign ntry)	
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21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. sd other than "natural", or ttems 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 □ X ever Married 2 □ Mar 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tyes 2	ss? ⊒No	1	ecedent of H specify Cuba s 2 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or N no Rican, etc.)	10- 14	14. Race - American Indian, Black, White, etc. SpecifyBlack		
9	2 hou		15. Decede	nt's Education	16a.	Decedent's	Usual Occup	ation		16b. Kind	of Business/In	dustry	
218	thin 7 e. an "n	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4)	or 5+)	life. DO NO	t work done o T use retired	during most of wo	orking				
21	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ine M	ပ်			So	rter				Unit	ed Pai	ccel	
nd	tal High doth	Be	17. Father's Name (First, Middle,						me (First, Middi	e, Maiden Si	umame)		
γ	2 should be 1 and Mental I Is marked or raumatic eve	ပို	Anthony Craic					Lisa F					
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relation: Lisa Flurry (and Number or F				Code)	
	t and Health am 27 ther tr		20a. Method of Disposition	mother)	20b. Place of	Disposition	elmar Name of	Rd. C	herry Date		21225 ition - City or To	State	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke eny Injury or other traumatic. 000ce.		1 XBurial 2 ☐ Cremation	3 □Removal from Sta	te cemeter	y, crematory	or other plac						
뜶	artme artme ortant Injury		' 4 □ Donation 5 □ Other (\$ 21. Signature of Funeral Service		Sacre				16-05	Dund	alk, M	1D	
Ba	permit. Departr Importa eny Inju		Dan 200 7	P // 7	_			ss of Facility W					
			23a. Part1. Enter the disease, o	r complications that cause	sed the death. Do n	ot enter the	East mode of dyin	ern Av	e Bal	CO. M arrest.	D 2123	Approximate	
			shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Onset and Death										
	/Medical		disease or condition resulting in death)	a. GUNS F Due to (or	as a consequence of		of	MBOOK	VEN				
	Examiner		Sequentially list conditions	b									
	ם א	Iner	Sequentially list conditions, if any, leading to immediate cause Entire II declaring Cause (Disease or injury	Due to (or	as a consequence o	of):							
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189	physi the	dlcal		d	· · · · · · · · · · · · · · · · · · ·								
Вох 6	The law requires that the death certifi Ite has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ic pregnancy			230	d. Date of delive	ery Day Year	
o.	that the de led by the a detached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr	at time of death	5 🗌 Othe	(specify)						
<u>α</u>	that the ded by detact		Part II. Other significant conditi	ons contributing to deat	but not resulting in	the underlyi	ng cause give	en in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?	
ds,	uires sign ld be	d by		· ·	3	,	· · · · · · · · · · · · · · · · · · ·		- 11	Yes 2 🗃	_	ably 4 □Unknown	
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Re	The tavate has	m D							24a. Wa: auto		prior to cor death?	psy findings available npletion of cause of	
Vital Records,		e Co	25. Was case referred to medica						1 🔀 es	2 🗆 No	1.2 Kes	2 🗆 No	
⋚	sici cer rec	o Be	examiner? 1 X es 2 No	Hospital: 1 🗆 Inpa	atient 2 XER/Out	nationt 3	DOA Othe	Nr.	ath (Check only		704	1	
ō		Η,	27. Manner of Death	28a. Date of I	aium Took Ti		28c. Injury	at □ Nursing i	dome 5 ☐ Res 28d. Describe		Other (Specify	′)	
Division	t & F	Certification;	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation 6/8/0	Day Year) Tours	iury act PM	Work	(? Yes 2 ⊠No	SUBTE		AS SHE	T	
Σ	after death after death Director: In by the	rtlfl	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of building,	Injury - At home, far etc. (Specify)	m, street, fac	tory, office		City or To	wn, State)		Route Number,	
	Hospital or 4 hours afte Funeral Dir tely filled in I				KEET				1- 1300			AUTHORF HD	
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier 1 ☐ Certifyii (Check only 2 ★ Medical one)	ng Physician: To the be Examiner: On the basis and manner	of examination and	death occur Vor investiga	red at the tim tion, in my op	e, date and plac pinion, death occ	e, and due to the urred at the time	cause(s) an , date and pl	d manner as st ace, and due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifie		5141007		29c. License	number		29d. Date s	igned (Month, I	Day, Year)	
)	->-0		Duct.	2			OCM	E		T	0	2005	
			30. Name and address of person	who completed cause of	f death (Item 23a) (1	Type, Print)	l Penn	Street	Baltim	June ore. M	9 Maryland	2005 1 21201	
			31. Date filed (Month, Day, Year,	שואוס, ויוט									
	Sta Registr	- 1			strar's Signature	* 1	A BC						
Ditt	MH 17 Rev 1/20		JUN 1	6 2005	en &	for							
DHi													

State of Maryland / Department of Health and Mental Hygiene 1- State amend item #17 PER FH G849enticate/of59eath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** JOHNNIE FELDER 1025 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1650 Woodbourne Avenue Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1**∑**M 2□F 249-52-6005 70 Director 06/30/1934 SOUTH CAROLINA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show other traumatic event, the Madical Examinar must be notified at 1 √Yes 2 No Director N/A BALTIMORE CITY MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 items 23a E AVE, APT #220

12. Was Decedent Ever in U.S. Armed Forces? 21239 Completed by Funeral 1650 WOODBOURNE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes Ž∭No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER STEEL INDUSTRY 10TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be cormit. Pages 1 and 2 should be. Department of Health and Marimportent: If item 27 Ireny injury or correspond to the supplements. FELDER ADELLA DAVIS ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KAREN D. COFIELD / DAUGHTER 2126 PITNEY ROAD, PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ↓ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/05 | BALTIMORE CO., MD LORRAINE PK CEM. 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 meral Service Licensee A600 LIBERTY HEIGHTS AV Library that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or hear layure. List only one cause on each line. HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death a Horosele rotie Cardiovasce lar diate ause (Final a. HypevHusive

bue to (or as a consequence of): Physician dis hise condition (in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Lealetmia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Be Completed Drabetes millitus 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 🗌 Yes 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence her (Specify) at scene Certification: To Yes 2□ No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death Director: 6 Could not be determined 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 - Homicide within 24 hours aff To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 TMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number OCME 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 15, 2005 rellal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 61 31. Date liled (Month, Day, Year) 32. Refistrar's Signature State Registrar JUN 1 6 2005

			For State	State of Marylan		artment of F		Mental Hy	•	2005	20061
			Registrar 1. Decedent's Name (First, Middle, Last,			inoate or	- Calif	2. Date of D	Reg. No eath	O O O	3. Time of Death
	Physici		Gladys	E.		Fairley		Month	Da	y Pear	15:02 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	Dald	40	County of Death	
	LXamii		ThEJOHNSHOP	KINGHOSPIT	ral	Bultin.	ore Cit	4	W	lA	
	Funeral		Social Security Number 6. Sec.	7. Age (In yrs. i	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ax Year	9. Birth	place (State or Foreign
	Director		X10-30-997 F	M 212F	70 Yrs.	World is Days	110013		7075	934 Mi	ryland
	pur *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	/. Town or Lo	ocation					10d. Inside City Limits
	Aaryli F sho	5	mo N/a		Itimo						1 Yes 2 No
	28a-	ect	10e. Street and Number		1111110	10f. Zip Code			10a. Ci	tizen of What Cou	untry?
	3a or	Ö	2307 Ashland	Ave.		21205	5		LIST		,
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or N	0-	14. Race - Amer	
ဖွ	or ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba 1☐ Yes 2☐ No	Specify:	Hican, etc.)		Black, White	o, etc.
21215-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show likal Examinar musi ke notified at	d by	3 Widowed 4 Divorced	Year or Dates:		12.103 292.110				Specify: BIA	- X
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lan	ould be Mental tarkad o	To Be	Walter Gaines				Edith	Johns	00		
Maryland	2 shou and N is mar	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street	and Number or Rui	ral Route Numb	oer, City	or Town, State, Z	ip Code)
	1 and 2 Health a lam 27 is		Darlene Fairley -	daughter	2300	7 Ashlar		Baltim	pre,	mo ala	205
ore	of He of Herr	1	20a. Method of Disposition 1 Burial 2 Cremation 3 F		lace of Dispendence of the lace of the lac	osition (Name of matory or other place	ce)	Date		ocation - City or T	Fown, State
Ĕ	Pages ment of h ant: If its ury or of	. ,	'4 □Donation / □ Other (Specify)	me	tro (Remator	4 6-18	-05	Cato	proville	mb
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature o Ameral Selvice Licena	9/	G	2. Name and Addre		neral	Hon	ne P.A.	
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Ш			23a. Park. Epor the disease, or compleshock or eart failure. List only of	ne cause on each line.	n. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	dlcal		d							
9	ing pl	Med	IF FEMALE:								
Вох	death certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3[Ectopic pregnancy				23d. Date of deliv	very Day Year
0	the de	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of di 9□ Unknown	eath 5	Other (specify)	·				
Ω.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	by Physiclan/Me	Part II. Dther significant conditions con	ntributing to death but not rese	ulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Records,	uires sign ld be							1 🗆	Yes 2	.□No 3□Pro	bably 4 AUnknown
00	w requir been si should	Completed						24a. Wa:	s an	24b. Were aut	opsy findings available
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Į V	S	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Impatient 2	ER/Outpatie	nt 3 DOA Oth	00			6 ☐Other (Spec	ify)
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Sio	Attending r death. sctor: Atter	catle	2 Accident investigation			M 1 🗆	Yes 2 □No				
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, st /)	reet, factory, office		28f. Location City or To			ral Route Number,
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	To the Hospital or Attant within 24 hours after deatl To the Funeral Diractor: completely filled in by the	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	o the o the omple	Mec	29b. Signature and title of certifier	and mainter stated.		29c. Licens	e number		29d. Da	ate signed (Month	. Day, Year)
	r ≠ F ŏ		Kan M Vu	L MD		RES	-000		1	12	2005
	1		30. Name and address of person who or		23a) (Type.	Print)			00	1/2 / C	ردن
	(0 10 11	zer 600 N.	Wolfe	st Ba	Himore 1	MD 21	287		
	Sta Registr		31. Date fled (Month, Day, Year)	S. Registrar's Signa	ture do	de)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Charlotte Frederick /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 📆 🔭 Hours 75 212-32-8453 Yrs. Director 20. 1929 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or Itama 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland N/A **Baltimore** Director XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 West 37th Street 21211 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a enty Injury or other traumatic event. It a Medical Exporter must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: txXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZUX No Specify: þ Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph W. Frederick Agnes Myers ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Gall Sister 2D Saddletop Court Cockeysville, MD 21030 20b. Place of Disposition (Name of commetery, cramatory or other place)
Dulaney Valley Memorial 6/16/2005 Cockeysville, MD 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☐ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, REGUL 61797 ON Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 10 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) MIGHT PURNEAULIND of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address UMON MENORUM KUSPITA MP M.D. 32 Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** SAYMOND FLOYD 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balton (Editor 1 Year | If Under 24 Hrs. Care Nuising Home 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 ☐ F Days Hours Min 230-12-5760 Usual Residence of Decedent Yrs. Director June 10, 1933 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No **Funeral Directo** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code A filed within 72 hours after death 12. Was Dicedent Ev Armed Forces?/ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "ne any injury or other treumatic event, Ite Madic 2005. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) th Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) Baito Mrs.trance Street MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2 Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 **Y** Burial 2 □ Cremation oodlawn Cemetery June 16, 2005 Baltimore * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address Joseph Lings Funeral Home, 229 DW North Ave. Balto, MD ntelle 21216 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sayus disty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 🗆 No 2 1 Yes 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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2005 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salusa

Daljeet

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** therine anc 3, 2005 4c. County of Death line /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ric tomore 5. Social Seourity Number In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Days Min. Months Hours 1 □ M 2 V F 213-36-2594 Yrs. November 24,1959 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Race American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "m Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 1 17. Father's Name (First, Middle, Last) Be 19a. Informant's me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If itam 27 la Baito. inden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 N Cremation 3 ☐ Removal from State ö June 20,2005 4 ☐ Donation 5 ☐ Other (Specify) injury ematory 21. Signature of Funeral Service License Funeral Home, any Balto, orth MD 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner axy 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ enosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy Yes To tha Hospital or Attanding Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 No 2 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 5 Pending investigation death. 1 Yes 2 No 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SUM ress of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

		State of Maryland / Department		Reg.	- NE UU5	20058
Physic /Medi		Barbara A. Gaters			,Day2005 Year	4:08 P
Examir	ner	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Deal	th
Funeral Director		5. Social Security Number A 15-89-4193 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y)	ear) Co	thplace (State or Foreign ountry)
death with the Maryland ms 23e or 28e1 show	jor	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
ith the ? or 28a-	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Co	
death v ims 23a	nerai	2525 Salerno Place 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21202 Was Decedent of Hispanic Origin? (Spe	city Yes or No-	SA 14. Race - Ame	
036 urs after al', or ite	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	lf Yes, specify Cuban, Mexican, Puerto F 1□ Yes 2☑No <i>Specify:</i>	rican, etc.)	Specify: B/L	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinational be inclined at once.	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	ng	b. Kind of Business/	Industry
yland 2 yld be filed Mental Hygic arked othar attic avant, II	To Be Co	17. Father's Name (First, Middle, Last) Leon Gaiters SR.	18. Mother's Name	(First, Middle, Mai		,,
Mar nd 2 sho alth and 27 is my r traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir Timothy Valentine - husband 3525	ng Address (Street and Number or Rural		ity or Town, State, Z	
altimore, mit. Pages 1 ar partment of Hez portant: If item y Injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposementary, crematery, crematery	sition (Name of Danatory or other place)	ate 200	c. Location - City or	Town, State
Baltin permit. P. Departme Important any Injury		14 □ Donation 5 □ Other (Specify) 21. Signature Fundral Service Licen	Cemetery 6-10 Name and Address of Facility INTP: March Fune 10 Fredhillon Pass 2	ral Hom	nedowni	e, mo
Physician		23a. Part 1. Eater the disease, of complications that caused the death. Do not ent shock or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	41045	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death) a. Cardiac Arrythmia Due to (or as a consequence of):				
ed sit	iner	Sequentially list conditions, the local sequence of the local sequ				
18760, cate be executed physician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
I Records, P.O. Box 687 The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the I	Physician/Medio		Ectopic pregnancy		23d. Date of deli	very Day Year
cords, P	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.			the cause of death?
of Vital Records, Physician: The law requires t this certificate has been signe ral director, page 2 should be or	Completed			24a. Was an autopsy performed	l? death?	topsy findings available completion of cause of
Jing Jing After	tion: To Be	25. Was case referred to medical examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 1 Natural investigation			e 6	ify)
Division To the Hospital or Attending within 24 hours after death. To the Funaral Diractor; After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, strubulding, etc. (Specify)		Bf. Location (Stree City or Town, Si	t and Number or Ru tate)	ral Route Number,
e Hospit 124 houn e Funare letely fille	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, ar restigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month	
		30. Name and address of person who completed cause of death (Item 23a) (Type, INA RUO10, MP				
Sta	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street	t Baltin	ore, Mary	Land 21201

			For State Registrar	State of M	arylar	-	artmen			and M		gien	200		2006	0
Ī	Physici /Medic		1. Decedent's Name (First, Middle, Las Herbert R. Grohs	*							2. Date of De June 1	ath		'ear	3. Time of Death	M
	Examir		4a. Facility Name (If not institution, give 3648 Malden Avenue	2			Ba	1tim					c. County of			
	Funeral Director		5. Social Security Number 088-07-8605 6. Security Number 11	7. A	9e (In yrs. 87	last birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Bir (Month, Da July 7	th ly, Year 10		Coun	lace (State or Foreig try) York	gn
	e Maryland a-f show lifted at	ctor	10a. State 10b. County Maryland N/A		_	ty, Town or Lo		-						11	0d. Inside City Limit:	
	th with the 23a or 28	Funeral Director	10e. Street and Number 3648 Malden Avenu	ıe			10f. Zip	Code 1211				10g. Ci	itizen of Wh	at Coun	try?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, "the Medical Evanti arr must be notified at once.	by	11. Marital Status 1 □ Never Married 2€ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1XXYes 2 ☐ If Yes, Give Year or Dates:	No.	1	Was Deced f Yes, spec I ☐ Yes 2	_	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	Americ White, o	etc.	
Maryland 21215-0036	I within 72 ho lene. r than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		5+)		kind of wor OO NOT us	k done d e retired,	ntion furing most ginee		ing		(ind of Busin		lustry Engineerir	n.a
yland	ould be filed Mental Hyg karked other latic event,	To Be C	17. Father's Name (First, Middle, Last) Rudolpho Grohsko	·					18. Mothe	r's Name	Johan	, Maider	n Sumame)			18
e, Mar	1 and 2 sh Health and Sm 27 Is m ther traum		19a. Informant's Name/Relationship (7 Roxanne Grohskopf 20a. Method of Disposition		20h F	19b. Mailin	3648	3 Mai		Aven	ue Balt	imo	re, Ma	ary1	and 21211	l
Baltimore,	it. Pages intment of the intent: If ite njury or o'		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signatur of Funeral Service Licen)		ry1and	Vetei	her place Cans		. 6/			ocation - Cit	-	est, MD	
Ba	Depar Impo		23a. Part1. Enter the disease, or comp	. Hens	d the deat	Bu 36	irgee- 31 Fa	Hens	ss-Se Road	itz Ba	Funeral 1timore	Hoi Mar	me, Ir arylar	ıç.	21211 Approximate	
N.	Prr ysicia n /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as	17 /L	inso			D		ISE				Interval Between Onset and Death	
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8760,	cate be executed physician and the burial-transit	dical Exan														
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rds, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions co	ntributing to death b	out not res	ulting in the un	iderlying ca	use give	n in Part I.		23e. Did to			e contribute to the cause of death?		
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Division of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	To Be	To Be	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury				Othe Ic. Injury Work	r: 4□Nur	sing Hon 2	(Check only one) ne s Residence 6 □Other (Specify) 8d. Describe how injury occurred			
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	To the Hospitel or within 24 hours afte To the Funeral Director Completely filled in the	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best ner: On the basis o and manner st	f examina	wledge, death tion and/or inv	occurred a estigation,	t the time	e, date and inion, death	place, a	and due to the ded at the time, d	cause(s)	and manne d place, and	r as sta due to	ted. the cause(s)	
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	Sta Registr		31. Date filed (Month, Day, Year)	6 2005 Registr	Signa Signa	iture #	Low	Les .							l	

			For State Registrar	State of M	aryland		rtment of H tificate of L		nd Men	-	ene () ()5	200	70
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	/Medio Examin		4a. Fecility Name (If not institution, give College Manor Ass	4b. City, Town, or Luther		Death		4c. County	County of Death Baltimore					
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	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits		
	Mary First	tor	Maryland Baltimor	e	Lut	hervi	l1e						1 🗌 Yes	2 No
	or 28g	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Co.	intry?	
	e 23e		300 Seminary Avenu					1093	2 (014	VN-	USA		and tadion	
936	be filed within 72 hours after death with the Maryland Hygiene. d other than "netural; or iteme 23e or 28a-f show event, the Medical Execult at relative notified at	by Funeral	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2/5/ If Yes, Give Year or Dates:	?	1	Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2021 No	spanic Origin n, Mexican, P Specify:	n? (Specify Puerto Ricai	Yes or No- n, etc.)		ck, White	ican Indian, , etc. ite	
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ary	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	F	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street a	nd Number o	or Rural Roi	ute Number,	City or Town,	State, Zi	p Code)	
∑	and 2 lealth m 27 in		Betty E. Butcher	Daughter			D BOX 500	13 Ba	ltimo	re, Ma	ryland	21	211	
Jore	ages 1 nt of H : if ite		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐		CB	metery, cren	sition (Name of natory or other place Cemetery	6/	16/20		Oc. Location		own, State ryland	
Baltimore,	permit. Pages 1 and 2 should be Department of Heatland Mental Importent: If item 27 is marked any njury or other treumatic evons		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenses)		1)		Name and Address	1						
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	ĺ		30. Name and address of person who of	Inpleted cause of d	death (Item	23a) (Type,	Print) CHAI	ries	ST	#41	(512	LTO 17	(30)
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Anna Grace Garmer June 15 2005 5:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 3110 Paulskirk Drive Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 218 14 4729 Maryland Director 81 1924 Apr 2, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Exeminer must be notified at Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 3110 Paulskirk Drive 21042 United States Completed by Funeral death items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be of Health and Mental item 27 is marked or r other traumatic eve Mental George Kalb 2 Marie Bonjonia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Garmer/Husband 3110 Paulskirk Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 6-18-2005 Pikesville, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Smulles **Physician** OVERINU CONCETZ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 0 Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s 1 ☐ Yes 2**☑** No Division of Vital 28Z No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) ۵ 1 ☐ Yes 2√2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined n 24 hours after de he Funeral Directo pletely filled in by tt 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature afted title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIS leted cause of death (Item 23a) (Type, Print) 30. Name and address of pe ATRITCIE MICHOLUS KEUTI

State

Registrar

31. Date filed (Month, Day, Year)

JUN 16

		1 - State of Maryland / Department	artment of Health and Mental H rtificate of Death	lygiene 05	20072
		Decedent's Name (First, Middle, Last)	2. Date of I	Death	3. Time of Death
Physical Phy		ANNA M. HANDY	Month O6	Day Year	- 1555 M
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	th
		Good Samaritan trospital	Baltimore	N	
Funeral		5. Social Security Number Control of the security Number 6. Sex 7. Age (In yrs. last birthday) 7 7 7 7 7 7 7 7 7	Months Days Hours Min. Month,	Day, Year) C	thplace (State or Foreign
Director		Usual Residence of Decedent	06.17	. 1927	MD
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e-f sl	cto	MD NA BALTIMORE	=		1 LYes 2 □ No
or 28	Oire	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
ath w	Funeral Director	901 CHERRY HILL ROAD # 31A	21225	USA	
er de	une	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Whi	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [M]No If Yes, Give 3 M Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🗹 No Specify:	Specify: BL	ΔΛΥ
2 hou	ted	15. Decedent's Education 16a, Deced	dent's Usual Occupation	16b. Kind of Business	
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그 등원금					
Permi Impo any k		Vauch Com	2. Name and Address of Facility NUGHN C. GREENE FUNERA 51 BAUD. NATU PIKE, BAUD	. MD 21229	
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/Medical Examiner		resulting in death) Due to (or as a consequence of):			2 / 12041)
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death certific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy	23d. Date of de	,
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or At fter d Direct in by	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		ู (Street and Number or Ru own, State)	iral Route Number,
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Monti	
0/1		I terrestay, MD	Res 000	06/11	12005
3		30. Name and address of person who completed cause of death (Item 23a) (Type, I) Dm, Fri SOUZCLOUNTSK!	Print) Res 000 U.D. 5601 Loch RAVE	er Blud BAL	tronare. MIN
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,,-	2/239
Registr			hours !		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.

Physician /Medical Examiner

Funeral

Director

or than "naturel", or itams 23a or 28e-f show the Medical Examper must be notified at is marked other Pages 1 and 2 should be nent of Health and Mental sht: If item 27 is marked o

Director

by Funeral

Completed

Be

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

permit. Page Department of Importent: If any injury or once.

attending physician

Physicien: The law requires that the death certificate be executed

or Attending

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within 24 hours a

eht tilled in by the

Division of Vital Records, P.O. Box 68760,

Examiner by Physician/Medical Completed Be Certification:

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 06 Year 0452 M ARTHUR FRANCIS HUDGINS 2001 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNAPOUS 1240 AUG USTA AVENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 - 03 - 1922 Birthplace (State or Foreign Country)

MD 5. Social Security Number 7. Age (In yrs. last birthday) 1**⊠**M 2□F 82 215.12.3513 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MD ANNAPOUS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1240 AUGUSTA AVENUE 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 K Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 4 YRS. Elementary/Secondary (0-12) ARMY OFFICER MILITARY 1214 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RICHARD HUDGINS BERTHA ANDERSON 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 BBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS 06.16.05 BALTO. MD 21. Signature of Funeral Service Licenses VAUGHN C. GREENE FUNERAL SERVICE Vangh 5151 BALTO, NATU PIKE, BALTO, IVID 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or han failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed Yes 12 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home Seridence 6 Other (Specify) 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of centifier?

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

44 T DEFENSE Highway

			1 _ For	State of Ma		Depa	artment of H	lealth a		ental Hyg	6	005	20074
			Registrar 1. Decedent's Name (First, Middle, Last))		00,		Douin		2. Date of Deat	eg. No. th		3. Time of Death
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	/Medic		Robert W. Har 4a. Fecility Name (If not institution, give				4b. City, Town, or	r Location o	of Death	June	_	2005 nty of Death	10:45 ^A
	Examir	ner		street and rumber)									
_			6761 Pirch Way 5. Social Security Number 6. Se	7 Ag	e (In yrs. last i	hirthday)	If Under 1 Year	idge	24 Hrs.	8. Date of Birth	Ho	oward	place (State or Foreign
	Funeral Director			XM 2□F	62	Yrs.	Months Days	Hours	Min.	8. Date of Birth Jan 22,	1943	Mary	place (State or Foreign htry) y Land
			Usual Residence of Decedent									TRAL	yrana
	yland IOW		10a. State 10b. County		10c. City, To	own or Lo	cation					1	0d. Inside City Limits
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	ms 2	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba	ispanic Orig	gin? (Spe	cify Yes or No-		lace - Americ	
9	after or Ite	F	1 ☐ Never Married 2 🌠 Married	1 Yes 2 X	No		1 Tes, specify Cuba 1 ☐ Yes 2 XNo	Specify:	i, Fuerto r	ncan, etc.)		lack, White,	
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<u>ya</u>	should be and Mental I	2	Glen Harper		_					Hitchen			
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. It it item 27 is marked other then. It item 27 is marked other then natural; or items 23a or 28e-f show or other traumatic event, the Modical Examiner must be notified at		Sharon Harper, Wi	te			Pirch Wa						
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Baltimore,	permit. Pages Department of t important: If ite any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation '5 ☐ Other (Specify)		Metro		ematory I						Maryland
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x 68	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:										
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal dea		Ectopic pregnancy	,			I .	Date of delive Month	ory Day Year
<u>o</u> .	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 _	Other (specify)						
Θ.	The law requires that the de ate has been signed by the a page 2 should be detached	Ph	Part II. Other significant conditions co	ntributing to death h	ut not resulting	n in the u	nderlying cause giv	en in Part I		23e. Did tol	pacco use co	ontribute to th	ne cause of death?
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		Ç								perform 1 Yes	2 X No	1 Yes	2□ No
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	5 × 5 0		255. Signature and the of Certifier	^						-	/ .	1	
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1	•		30. Name and address of person who c	ompleted cause of c	leath (Item 23	a) (Type,	to mai	in R	A1"	TMI	n -		79
	0:		31. Date filed (Month, Day, Year)	35 Ranietr	ar's Signature		JOHON	at D	1) -	1110		112	<u></u>
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:00 AM Henri Authens NN 90 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GROUG Baltimore AKENUR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Manth, Day, O'4 - 21) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months 65 216-62-8952 Yrs. Director amaica Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumetic event, the Michael Examiner must be notified at Baltimore 1 **X**es 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 5508 21212 12R Funeral 12. Well Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give or Items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Blac by 3 Widowed 4 Divorced 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) touse kee marked other 17. Father's Name (First, Middle, Last) r's Name (First, Middle, Maiden Surname) t and 2 should be fit Health and Mental H tem 27 is marked ott Moore armeng 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other tree -Suffolk VA 23434 20c. Location - City or Town, State Henry (son) Holland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. ö Belvedere -30-05 Red Hills Jamaica 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fallity 4905 Baldimore Lecus York Road 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician loidosis 6 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to [or as a consequence of] attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 2√ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending Division 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 144 31. Date filed (Month, Day, Year) State Registrar 1 6 2005

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Joan E. Hensley рм June 14 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3310 Benson Avenue, Apt. 213 Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 27, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. 212-30-5287 71 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Exeminer must be notified at 1 XYes 2 No Director Maryland n/a Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3310 Benson Avenue, Apt. 213 21227 United States or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or fler may injury or other traumatic event, the Medical Exertines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bernard Walther UHK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Wayne Hensley / Son 602 Wingleaf Court, Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Park 6/17/2005 Glen Burnie, Maryland □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21 Signatur of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician congestive Six years disease or condition resulting in death) /Medical Due to (o) s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attanding within 24 hours after death.
To tha Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 🗌 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D5366 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chora 31. Date filed (Month, Pa) egistrar's Signature State 2005 Registrar

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			Registrer 1. Decedent's Name (First, Middle, Last)		. Date of Death	3. No. U U)	3. Time of Death				
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ш	Director		224-40-4269 10 10 24 68 Yrs.	Notes Notes	(Month, Day, Y Mar. 28,	1937	Virginia				
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	the N	ect	10e. Street and Number 10f. Zip Code		100	g. Citizen of What (
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(0	r Her	교	Armed Forces? If Yes, specify Cuban, N		can, etc.)	Black, Wh					
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m	Depar Impo		2719 Hammonds								
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	Fo the within Forth	Me	29b. Signature and title of certifier 29c. License nu		29d	. Date signed (Mor	nth, Day, Year)				
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			1 - For State Registrar	State of Marylar			Health and I		_	20078
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	Funeral		5. Social Security Number 6. Se	TM 27€		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9.	Birthplace (State or Foreign Country)
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	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
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9	or It	Fu.	1 Never Married 2 Married	1 ☐ Yes 2 M No	j	1 Pes, specify cub. 1 □ Yes 2 🖾 No		o rican, etc.)		hite, etc.
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9	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23s or 28s-1 show a other than "natural", or Items 23s or 28s-1 show aword, the Modeal Exercities or all be a chilled at		17. Father's Name (First, Middle, Last)		Homei	naker	18. Mother's Nam	ne (First, Middle, Ma	Own H	ome
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altimore,	of Head		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of	1	Date 20	c. Location - City	
Ē	Page nent c int: If		1 M Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State Du.	laney V	natory or other place Valley Gardens	⁽⁰⁾ June 20		Timoni	ım MD
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	10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)	1200	20 AO	SUITTE	110
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	Registr	4	29b. Signature and title of certifier Symposium 30. Name and address of person who co Sh Arun M Ar 31. Date filed (Month, Day, Year)	. 6 2005 Bess	6. J. S.	Paralle	9			

Hudson, Mary

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Der	Funeral	11. Marital Status	12. Was Decedent Even	er in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto l	Rican, etc.)		ice - Amen ack, White,	can Indian, etc.
XS	by F	1 ☐ Never Married 2√2 Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2/13/ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No Sp	pecify:		Speci	ify:	lack
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other treumatic		19a. Informant's Name/Relationship	o (Type, Print)	19b. Mail	ing Address (Street and I	Number or Rura	d Route Number,	City or Town	n, State, Zij	o Code)
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to lo		20a. Method of Disposition XIXBurial 2 ☐ Cremation 3	B □Removal from State	cernetery, cre	osition (Name of matory or other place)		4	20c. Location		
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any injury or of		21. Signature of Funeral Service Lie	censee All	177.4	arch ^{and} For Hs of					
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		2 a. Part 1. Enter the disease, or co mock, or heart failure. List or	omplications that caused th	ie death. Do not en						
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cian		Ir ediate Cause (Final	ACI	ITE R	ESPIRATO	DRY F	ALLUR	F		Interval Between Onset and Death
ical iner		In ediate Cause (Final is ase or condition resulting in death)	ACI	ITE R	ESPIRATO	DRY F	ALLUR	F		Interval Between Onset and Death
ical ner	10	is ase or condition resulting in death)	a. Due to (or as a c	ONGEST	ESPIRATO VE THER	DRY F	ALUR	モ		Interval Between
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	Physici	an	1. Decedent's Name (First,	Middle, Last)		1/01	11-		2. Date of Death Month JUNE	_Dav Year	3. Time of Death
	/Media	al	4a. Facility Name (If not inst	itution airo s	troot and number	HOLI	4h Shy Town	or Leasting of Death	JUNE	7, 2005	1830 P M
	Examir	er	JOHNS HOPKIN	-				or Location of Death		4c. County of Death	10
	Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. last birth		r If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign intry)
	Director	<	216-90-203	7	M 2□F	28 Y	rs. Months Day	3 110013 14111.	2-12-	1977	Mdo
	show		Usual Residence of Decede 10a. State 10b. Co			10c. City, Town	or Location				10d. Inside City Limits
	with the Maryland a or 28a-f show	tor	Md.	MI	4	BAC	TIMORE	E			12 Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number	, ;	2	57	10f. Zip Code		10	g. Citizen of What Cou	intry?
	death w	ral	1315 N	· ///	11EK301	Y TARK		2101	3	4.5.	A.
10	vurs after death v al', or itams 23a Examinat must	Fune	11. Marital Status 1 X Never Married 2 □		 Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 		If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
036	hours after tural', or ita al Examina	by	3 ☐ Widowed 4 ☐ Dive	1	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1 ☐ Yes 2 2 N	o Specify:		Specify:	ACK
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	e filed Il Hygid other vent,	Be Co	17. Father's Name (First, Mi	ddle, Last)	10/10			18. Mother's Nam	e (First, Middle, M		C 1.2014
/lar	2 should be and Mental Is marked or raumatic ever	To B	FRANK	/	HOLM	ES		BASON	OKIG C	Utillin.	125
Maryland	and and sum		19a. Informant's Name/Rela	tionship (Typ	ne, Print)	196.	Mailing Address (Street	et and Number or Rur	al Route Number,	City or Town, State, Zi	
_	of Health item 27	-	20a. Method of Disposition	U.C.L.II	AMS/ME	20b. Place of I	Disposition (Name of	PATTERSON	Date 2	Oc. Location - City or T	121. 2155
Baltimore,	ages ant of it: If it y or o		1 Burial 2 □ Crema 4 □ Donation 5 □ Oth		emoval from State	cemetery	crematory or other p	lace)	1/100	Installe and	own, state
aĦ	parmit. Pages Department of Important: If i any injury or o		21. Signature 4 Funeral Se		9/7	111	22. Name and Add	ress of Facility	KERLY D.	CROMPL	THE ELC
ä	Depar Impor any ir		Beur.	full	ROTALINE	tee	2431 E.	OLIVER	37.	BALTO.	M. 21313
		4	23a. Part1. Enter the diseas shock, or heart failure.	e, or complic List only on	ations that caused e cause on each li	the death. Do no	/ /		or respiratory arres	st,	Approximate Interval Between Onset and Death
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687	as as	ledlcal		0.					10.00		
Вох	requires that the death certifi aan signed by the attending I hould be detachad for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnar		c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopic pregnan	cv		23d. Date of deliv	,
	he dea the at	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5 Other (specify)			Month	Day Year
P.0	that the		Part II. Other significant co	nditions cont	ributing to death b	ut not resulting in t	he underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Records,	w requires that the debase signed by the should be detached	ed by	~						1 ☐ Yes	2 No 3 □ Prot	pably 4 Unknown
900	0 -	Completed							24a. Was an autopsy		ppsy findings available
Ä	sicien: The law certificete has b irector, page 2 s	Com							perform	ed? death?	mpletion of cause of 2 No
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o	> 0 0	. To	1X Yes 2 ☐ No 27. Manner of Death		1 L Inpatie		atient 3 DOA	4 🗀 Nursing Ho	me 5 Residen 28d. Describe how	ce 6X10ther (Specification)	SCENE SCENE
ion	Attending r death. sctor: After by the fune	atlor		ending vestigation	28a. Date of Injui (Month, Date 6/7/05	_ ////	irv W	ork? □Yes 2XNo	aubrict	shot	
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Q	pital o urs aff arel Di					unl	nowh			eet and Number of Rura State) Block 1 Unifice (Fel)	
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 Cer (Check only 2 Med one)	lifying Physi lical Examin	er: On the best of er: On the basis of and manner sta	examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occurr	and due to the cau red at the time, dat	use(s) and manner as s e and ptace, and due to	tated. o the cause(s)
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Me	29b. Signature and title of ce	rtifier		10		nse number ME	290	d. Date signed (Month,	Day, Year)
	0		· Cah	ill	108/	15		enta	J	UNE 8, 200)5
	7		30. Name and address of pe	rson who con	npleted cause of d	eath (Item 23a) (T	/pe, Print) 111	Penn Stree	et Balti	more, Mary	land 21201
	Sta	te	31. Date filed (Month, Day,	'ear)	2. Registra	ar's Signature					
	Registr		JUN 1 6	2005	Blown	It for	arte				
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			1- State Registr amend item #]	State of Mary					giene Reg. No.	05 20081
	Physici		Decedent's Name (First, Middle, Last) HILDRE	MTTPAKEN		SCHFELD RSCHFIELI	n	2. Date of De. Month	Day	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give		11:11		or Location of De	JUN_ath	9 2005 4c. County	
	Exami	10.	NATIONAL NAVAL M	EDICAL CENT	ER		ETHESDA			ONTGOMERY
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 H	s. 8. Date of Birt		Birthplace (State or Foreign Country)
	Director		224-20-3370	M 2₹F 89	Yrs.	Months Days	Hours Mi	8. Date of Birt (Month, Da Aug 31	1915	Virginia
	and *		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10111100000
	/anyi	ō								10d. Inside City Limits 1 ☐ Yes 2√☐ No
	28a-	ect	MD Worceste 10e. Street and Number	r	Berl	10f. Zip Code			10- Chin(1)	A
	Sa or		754 Ocean Parkwa	v		218	R11		10g. Citizen of V USA	
	death ms 2:	Funeral Director		12. Was Decedent Eve	r in U.S. 13.			Specify Yes or No-		e - American Indian,
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, It e Medical Examiner coast by motified at	E	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ No		If Yes, specify Cuba	an, Mexican, Pue	irto Rican, etc.)	Btac	ck, White, etc.
933	ours iral',	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	43-52	1 ☐ Yes 2 🔀 No	Specify:		Specify	white
21215-0036	natu	Completed	15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	orkina	16b. Kind of Bu	usiness/Industry
121	within ane. than	m l	Elementary/Secondary (0-12)	College (1-4or 5+)			d)			
d 2	Hygie Hygie ther ant,		12 17. Father's Name (First, Middle, Last)	4	te	acher	18 Mother's N	ame (First, Middle,	educa Maidea Sumam	
an	d be ental ced o	To Be	Orin Dereiux Myri	ck				lae Johnal		16)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. If Health and Mental Hygiene. It file may is marked other than "natural", or Items 23a or 28a-f show other traumatic event, It a Marolcal Examiner chast be notified at	-	19a. Informant's property and information (Ty)		19b. Maili	ng Address (Street		Rural Route Numbe		State, Zin Code)
Σ	and 2 ealth a n 27 is	l y	Susan Fersten /dau			Bay Stree			1811	Siato, 25p 0000)
ore,	es 1 an of Heal fitem 2 rother		20a. Method of Disposition	i	Ob. Place of Dispo	-	1	Date	20c. Location -	City or Town, State
Ē	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☒ Donation 5 ☐ Other (Specify)	emoval from State	1	Timery or our, or piece		1		
Baltimore,	permit. Pages Department of Important: If is any injury or o		21. Signature of Fundral Service Disense Ronal U.S. V	vade Viv	tor S	2. Name and Addrestate Anat altimore,	omy Boar	cd 655 W.	Baltimo	ore Street
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the	death. Do not ent	er the mode of dyin	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	hysician	8 9	Immediate Cause (Final disease or condition		MONIA					Onset and Death
	/Medical- Examiner		resulting in death)	Due to (or as a co						
	xaniinci	Ļ	Sequentially list conditions,	. Due to /or or or						
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)	Due to (or as a co	nsequence or):					
	axecu al-tra	Examin	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
68760,	icate be executed physician and sthe burial-transit	dical								
		a)	-							
Вох	death certiff e attending I id for use as	Physician/M	250. Was decedent pregnant	3c. If yes, outcome of p		Ectopic pregnancy			23d. Date	of delivery
	0 0	sici	in the past 12 months? 1 Yes No	4☐Pregnant at time 9☐Unknown		Other (specify)			Mon	nth Day Year
P.0	mat me de ed by the a detached	Phy	9 Unknown							
Ś.	se us	by	Part II. Dther significant conditions con	tributing to death but no	t resulting in the ui	nderlying cause give	en in Part I.			bute to the cause of death?
ecords,	w requir been si should	etec							s ZAJNO	3 Probably 4 Unknown
Rec	25 0	Completed						24a. Was a autops perfor	sy p	Vere autopsy findings available rior to completion of cause of eath?
			00 11/2							eam? ☐ Yes 2 ☐ No
Vital	rnysician: this certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 🔀 Inpatient	·	Othe		ath (Check only on		
		\vdash	27. Manner of Dea	28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. Injury	/ at	Home 5 Reside		
ion	Attending of the death. actor: After by the funer.	tlor	1 XNatural 5 ☐ Pending investigation	(Month, Day Ye	ar) Injury	Work	<br Yes 2 □ No			
Division	after death after death Director: ,	iffice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	At home, farm, stre	eet, factory, office				r or Rural Route Number,
	tal or	Certification:	4 Chomicide	building, etc. (S	овспу)			City or Towi	n, State)	
	vithin 24 hours after of Al To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my er: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the time restigation, in my op	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, d	ause(s) end mar ate and place, a	nner as stated. nd due to the cause(s)
3	vithin 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, Day, Year)
)	, - u) LA	V.1/	M	0101	237286 ((VA)	June	9 2005
			30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type,				AT, MEDIC	CAL CENTER
			RICHARD A. CATHER	INA LCDR	MC USN			IESDA MD		
*:	Sta Registra	- 2	31. Date filed (Month, Day, Year) JUN 1 6 2005	39. Registrar's S	Signature	E. 1				

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Jennie M. Inskeep 6:12 06 15 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Hespital

5. Social Security Number 6. Sex R. Age (In yrs. last birthday) Rosedale

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 81 Yrs. **Director** 215-18-6817 10/4/1923 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Modical Examinar must be notified at MD Baltimore Baltimore, 1 ☐ Yes 2X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 Kelso Drive, 102 21221 Completed by Funeral Apt. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 72 hours after ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married 21215-0036 1 ☐ Yes 25 No Specify: Spacify: White 3 ☐Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 8th Western Electric Machinist land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Orazio Santanoceta Santa Mangano Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ertment of Health ortant: If item 27 Dewalt Bender/son 8100 Redstone Road Kingsville, MD 21087 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 6/18/05 Baltimore, MD pern it.
Deportr
Imports
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WITH Sepsis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 nonths?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo Year Dav 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2. No 1 ☐ Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy performed certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 Tyes 2 Accident investigation hours after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0006 1337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD 21237 Dr. Kirmani Ahmed 31. Date filed (Month, Day, Year) State Registrar

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			For State	State of Maryland / Department of Health and N		2005 211183
_		_	State Registrar	Certificate of Death	Reg. I	
	Physicia	an	Decedent's Name (First, Middle, Last)	the state of the s	2. Date of Death Month	Day Year 3. Time of Death
	/Medic		HAMMAHI	JONES	June_	11, 2005 09:30 AM
	Examin	er	4a. Eacility Name (If not institution, give s	treet and number) 4b. City, Town, or Location of Death	,	4c. County of Deathy
				urs Hospital Baltimo	se I	NIA
	Funeral		5. Social Security Number 6. Sex	M 2 F Yrs. When the state of th	8. Date of Birth (Month, Day, Yee	9. Birthplace (State or Foreign Country)
	Director	}	0175050010	5 8 115.	August 2,	1946 Virginia
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	<u> </u>	10d. Inside City Limits
	sho	5	11.	D . 1 .		1 Q ves 2 □ No
	88-f	ect	Maryland N/F	Baltymore	10-	Citizen of What Country?
	vith t		10e. Street and Number	10f. Zip Code	109.	Citizen of What Country?
	s 23	by Funeral Director	110 No HI	Iton Street Alang		14. Race - American Indian,
	er de	nue	1 11 Indition States	Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White, etc.
36	s aft	Ž	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 MD No If Yes, Give 1 ☐ Yes 2 MD No Specify: Year or Dates:		Specify: 12 Cal
21215-0036	within 72 hours after death with the Maryland ene. then *netural; or items 23e or 28e-f show the Medical Examer Innet Le modified at	De la	15. Decedent's Edu		16h	. Kind of Business/Industry
15	n 72	Completed	(Specify only highest grade	(Give kind of work done during most of work	king	. Thing of Business industry
12	withi ene. then	μŽ	Elementary/Secondary (0-12)	College (1-4or 5+)	1.1	1 S Forernment
	filed Hygir other ant, I		17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	(en Sumame)
a	ould be Mental arked o) Be	11/2/01/	TORES	nob -	Taular
\mathbf{z}	should be nd Mental marked o	ပ္	19a. Informant's Name/Rell tionship (Ty	pe, Print) 19b. Mailing Address (Street and Number or Ru	ral Route Number Cit	y or Town State Zin Code)
Maryland	C/ c/ 20 00		Mc Charle 10	white DIAN Hilton St	at Dal	west waster only
_	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other tr 2002.		20a. Method of Disposition	20b. Place of Disposition (Name of	Date 20c.	TO MD 21299 Lo ation - City or Town, State
Baltimore	Pages nent of I nnt: if ite iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	amoval from State cemetery, crematory or other place)	. 48.1	ansdowne MD
ij	permit, Pages Department of Importent: If If eny injury or o		'4 □Donation 5 □Other (Specify)		17,2005 L	
3a	permit. Departr Importe eny inji		21. Signature of Funeral Service Livense	22. Name and Address of Facility	Pain	
	7 C1 = 0 C4		Tatelle P.	passes of the Daddw. North +	he But	, MD 21216
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that daused the death. Do not enter the mode of dying, such as cardiac e cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	3	Immediate Cause (Final disease or condition	coronary friting,	Discas	5,105, 2,10 552,11
	/Medical		resulting in death)	Due to (or as a consequence of):		- /
	Examiner		Sequentially list conditions	congestine Hea	It la	Milia
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)		
>	w requires that the death certilicate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal Examiner	that initiated events			
Ò,	e exe ian a urial-	Ĕ	resulting in death) Last	Due to (or as a consequence of):		
3760,	ate b nysic he bi					
68	The law requires that the death certifica ate has been signed by the attending phagge 2 should be detached for use as the	Physician/Med	IF FEMALE:			
Вох	th ce tendi r use	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□ Fetal death 3□Ectopic pregnancy		23d. Date of delivery Month Day Year
-	dea od fo	scl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 Other (specify)	T-12-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	World Day Feat
P.O.	at the by the	h	9 🗆 Unknown			
	as tha	by		tributing to death but not resulting in the underlying cause given in Part I.		to use contribute to the cause of death?
ğ	quire an siç ould b	ed	Chronic Gust	ructure Lung Diseas	1 ☐ Yes	2 No 3 Probably 4 ⊕Unknown
Division of Vital Records,	awre s be	Completed by	Hypertensi	on Diabelis mellitus	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The la	E	-/-		performed	? death?
tal	en: tifica tor, p	0	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
5	Physicien: this certificated director,	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)
9	g Phy er thi	n.	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in	
on	Attending it death. ector: After by the fune	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No		
<u>/isi</u>	Atter	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number,
Ö	afte Dire	Certification:	4 Homicide	building, etc. (Specify)	City of Town, 31	ato)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	alc		sicien: To the best of my knowledge, death occurred at the time, date and place,		
	ie Ho 124 1e Fu letely	Medical	(Check only 2 Medicel Exami- one)	ner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, date a	and place, and due to the cause(s)
	분 등 분 은	×	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
	<u>₽</u> ₹ ₽ 5	-		1451CIAN 157547	2	6-13-05
•	Vit To			() 3/ 2/ 2/ 2/ 2 1 1 1 7 / 3 7		0 / /- 0 0
•	Viit Con	_		1.33.13		0 / / = 0 0
•	To voin		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print)		
	P N N N N N N N N N N N N N N N N N N N			mpleted cause of death (Item 23a) (Type, Print)		BALTINORE, MP2122

DHMH 17 Rev 1/2001

Physic		 Decedent's Name (First, Middle, I 			artment of CS45 7-17 Tifficate of		2. Date of Dea		3. Time of Dea
78 0 - E13		Raymond L. Joh:	nson				Month JUNE	7, 2005	
/Medi Exami		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Dea		4c. County of De	
		UNIVERSITY SPECI	ALTY HOSPITA	L	BALTI	MORE			
Funeral		,	. Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days			y, Year) 9. Bi	rthplace (State or Fo
Director	Ļ	274-28-6607 Usual Residence of Decedent	· K	/0 Yrs.			Sept 17		io
MOM		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Li
r 28e-f ehow	tor	MD Anne A	rundel	Pasa	dena				1 ☐ Yes 2√
or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
23a	rai	325 Bayfront Dr	ive			21122		USA	
or items	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
. o.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Vac Gara	57-69	1 ☐ Yes 2 🙀 No	Specify:		Specify:	white
"netural". dical Exa		15. Decedent's			dent's Usual Occu	nation		16b. Kind of Business	
n u	Completed	(Specify only highest of	rade completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking	TOD. Naid of Business	villoustry
I Hygiene. other then rent, I to M	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5		acher			education	
al Hygi l other vent, I	Bec	17. Father's Name (First, Middle, La.	st)			18. Mother's Na	me (First, Middle,		
Mental arked o	10	Raymond L. J	ohnson Sr	200		Esther	Chrstine	Baker	
n and Mental Its marked reumetic ev		19a. Informant's Name/Relationship						r, City or Town, State,	Zip Code)
Health tem 27		Barbara Johnso	n/spouse		10	Drive P	asadena,		
Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23a or may hijury or other treumetic event. Its Medical Examinar must be once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 '4 ☒Donation 5 ☐ Other Spec		20b. Place of Dispo cemetery, cres	osition (Name of matory or other pla	сө)	Date	20c. Location - City or	Town, State
Departr Import any inju		21. Signature of Euneral Service Lic ROHa I d S	Wade, Dire	ctor Si	2.Name and Addre tate Anat altimore	ess of Facility Omy Boar MD 212		Baltimore	Street
Medical aminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. If the Uniterlying	b. Due to (or as a c	onsequence of):					
cian and ourial-transit	il Exa	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
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	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, 1050) 4a. Facility Name (If not institution, games and 1000)	B. Kelly	1 de	4b. City, Tow	n, or Location of		Date of Death Month Di	ay Year O 200 c. County of Dea	th
	Funeral Director		5. Social Security Number 220-22-6776 Usual Residence of Decedent	Sex 7. Age (In 1⊠ M 2□ F 78	yrs. last birthday) Yrs.	If Under 1 Ye Months Da		4 H/s. 8. Min. 2	Date of Birth (Month, Day, Year — 7—192	y 9. Bir Mar	thplace (State or Foreign ountry) y Land
	with the Marylar or 28a-f ehow	Director	MD Worces 10b. Street and Number	ter	c. City, Town or Lo Ocean Ci	ty 10f. Zip Cod	le		10g. C	itizen of What Co	10d. Inside City Limits 1⊠ Yes 2 ☐ No puntry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id do other than "neturel" or Items 23e or 28e-f ehow event, the Medical Examiner could be a cylined at	by Funeral	9916 Golf Course 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?		21842 Was Decedent of Yes, specify C	of Hispanic Origi Cuban, Mexican, No Specify:	n? (Specify Puerto Rica		14. Race - Ame Black, Whit Specify: Wh	nican Indian,
Maryland 21215-0036	filed within 72 ho Hygiene. other than "netur ent, the Wedical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La.	rade completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most of tired)		Gr	ounds Ke	-
Maryland	should and Mer e marke	To Be	Joseph Bernard K 19a. Informant's Name/Relationship	e11y (Type, Print)			Flor	a L.	rst, Middle, Maider Groves oute Number, City	or Town, State, Z	
altimore, N	t. Page ntment o rtent: If njury or		Mary A. Kelly / 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	□Removal from State 20	b. Place of Dispo cemetery, cren leadowric	sition (Name of natory or other p age Memo	orial 6/	Date 15/20	05 E1k	ocation - City or ridge, M	Town, State
B	Fire ician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the copy one cause on each line.	2.7	719 Hamm	nonds Fe	erry R	d Lansdo	√ne, MD	21227 Approximate Interval Between Onset and Dealth
8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con Due to (or as a con Due to (or as a con		0					
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Vital Rec		e Completed	25. Was case referred to medical				26 Place of	1	24a. Was an autopsy performed? Yes 2 No eck only one)	24b. Were aut prior to co death? 1 \(\subseteq Yes	opsy findings available ompletion of cause of
o	ding Phys n. After this funeral di	ation; To B	examine 2 1	28a. ate of Injury (Month, Day Year	28b. Time of Injury	28c. Inj	Other: 4 🗆 Nursii	ng Home 28d. (5 Residence (fy)
Divis	To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	al Certification;	3 Suicide 6 Could not a determined		ecity)			1	ocation (Street and City or Town, State))	
	To the Hospital or A within 24 hours after To the Funeral Dires completely filled in by	Medical	(Check only one) 2 ☐ Medical Exa	miner: On the basis of exam and manner stated.	ination and/or invi	29c. Licer	opinion, death o	occurred at	the time, date and	place, and due to signed (Month,	o the cause(s) Day, Year)
	4		30. Name and address of person who	completed cause of death (I	tem 23a) (Type, F	Print)	16278 10 Ral	722 !	CALLERIA	-/0-0	21802
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	ander !	() . • 34Kl)	/JJ (114-1-00/	y pro	21002

DHMH 17 Rev 1/2001

KOPPLEMAN, JEROME

State of Maryland / Department of Health and Mental Hygiene 0 05 20086 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death JUNE **Physician** Koppleman, Jr. Jerome Charles 5.15 AM 14 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE ST AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sep. 29,1927 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F Months Days Hours 77 219-22-2759 MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "neturel", or Items 23a or 28e-f show the Medical Examinational be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Linthicum Direct 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 801 Oregon Avenue 21090 death v U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Heating and Air Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jerome Charles Koppleman, Sr. Anna Elizabeth Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Jones / daughter 1723 Underwood Road, Sykesville, MD 21784 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 17 WBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 2005 Hurlock, MD 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsib Physician /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician dbe detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No el or Attending Physicien: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) Manner of Peath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Hospitel within 24 hours a To the Funerel C 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of o 29d. Date signed (Month, Day, Year) D 59614 14 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOM MA, MD. STAGNES HOSPITAL 900 CATON AVE, BALTIMORE, ME CHANDRA 31. Date filed (Month, Day, Year) 32. pristrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

JUN 1 6 2005

	_	State Unpend Item 2 Registrar Decedent's Name (First, Middle, Last						2. Date of De			3. Time o	of Deat
ician dical		Dorothy Ann Ken	ny					Month May	27	2005	7:47	A
niner		a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation of Dea	ath	4c. Coun	ty of Death		
		2869 Baltimore B		·	_	nksbu				rroll		
al or	5	. Social Security Number unk 6. S	ex	(In yrs. last birthda 32 Yrs.	y) If Under Months		Hours Mir	n. (Month, Da	th ly, Year) 9, 1972	9. Birthpi Coun Penr	lace (State try) ISYLV8	
	_	Isual Residence of Decedent										
irector		0a. State 10b. County		10c. City, Town or	Location					10	Od. Inside C	•
Director	_	MD Carrol	1	West	minste						1 🗌 Yes	, ZX
	1	0e. Street and Number			10f. Zip		157		10g. Citizen of		try?	
iai	-	127 Stoner Avenu					.157		US			
by Funeral		1. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		If Yes, spec		Mexican, Pue Specify:	(Specify Yes or No orto Rican, etc.)		ace - Americ lack, White, o	etc.	
		15. Decedent's Ed		16a. Dec	edent's Usua	al Occupation	on		16b. Kind of	Business/Inc	lustry	
Completed		(Specify only highest gra	de completed) College (1-4or 5	(Girle	e kind of wo DO NOT us	rk done dur se retired)	ring most of w	orking				
E O		12	0		rsing	aide			he	alth		
BeC	1	7. Father's Name (First, Middle, Last)					8. Mother's N	ame (First, Middle	, Maiden Surna	ame)		ι
ToE												
		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address	(Street and	d Number or I	Rural Route Numb	er, City or Town	n, State, Zip	Code)	
		Bartholomew Salko	/spouse	228	Stace	y Lee	Drive	Westmins	ter. Mi	2115	Q:	
To Be Completed	2	0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🙀 Other (Specify	Removal from State	20b. Place of Dis cemetery, ci	position (Name rematory or o	ne of		Date	20c. Location			
once.	2	21. Signature of Funeral Service Licer		gror s	22. Name and tate A	Anator	of Facility Boan D 212	d 655 W.	Baltíu	ore S	treet	
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dicai Ex		esulting in death) Last	Due to (or as	a consequence of):								
Physician/Med) h	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pr					ate of deliver	,	Year
<u>م</u>	1	Part II. Other significant conditions o	ontributing to death bu	ut not resulting in the	underlying c	ause given	in Part I.		obacco use cor			
etec	-											
b Be Completed								24a. Was autor perfo 1 X Yes	rmed?	Were autop prior to con death? 1 \(\text{Yes} \)	rpletion of d	avail
Be		25. Was case referred to medical examiner?	Hospital:			Other		eath (Check only o				
	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA					^^	4 Li Nuising	Home 5 ☐ Resident			at so	en
ı		1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year) Injun	м	8c. Injury a Work?	s 2 No	200. Describe	iow injury occu	11180		
ı		2 Accident investigation 3 Suicide 6 Could not be		ury - At home, farm, : c. (Specify)			3 2 110	28f. Location (3 City or Tou		nber or Rural	Route Nun	nber,
ı		4 Homicide determined		of mu knowledge de	ath occurred							
ical Certification: To		29a. Certifier 1 Certifying Ph	ysicien: To the best on niner: On the basis of and manner sta	examination and/or	investigation,	r investigation, in my opinion, death occurred at the time, da 29c. License number 25			29d. Date signed (Month, Day, Year)		the cause(s)
ical Certification: To	1	29a. Certifier 1 Certifying Ph	niner: On the basis of	examination and/or		. License n						s)
Certification: To	1	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	niner: On the basis of	examination and/or					29d. Date sign	ed (Month, L		s)
ical Certification: To	2	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	niner: On the basis of and manner sta	examination and/or ted.	290	. License n				ed (Month, L		s)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimere Rondo 11stown enesis Ldercace If Under 24 Hrs. If Under 1 Year Funeral 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F 80 Yrs. Director 216-28-0880 10/03/1924 NORTH CAROLIN Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at XXYes 2□No Director MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5509 HIGHGATE or items 23e DRIVE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by 3

✓ Widowed 4 □ Divorced Specify: BLACK naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if item 27 Is marked other then "r any injury or other treumatic event, the Med appries. Elementary/Secondary (0-12) College (1-4or 5+) 6ТН RESTAURANT OWNER HOSPITALITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN ROLAND WILSON SALLIE L. STRONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLA L. JONES / DAUGHTER 5509 HIGHGATE DRIVE, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State V☐Burial 2 ☐Cremation 3 ☐Removal from State
4 ☐Donation 5 ☐ Other (Specify) DRUID RIDGE CEM. 6/20/05 PIKESVILLE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 HEIGHTS AVE., BALTIMORE, 4600 LIBERTY ler the discase, or complications that caused the death. Dineart failure. List only one cause on each line. MD not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death **Physician** CEREBRO VASCULAR 30 days /Medical resulting in death) Due to (or as a consequence of): **Examiner** STAGE END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy performed? certificate 2 No Division of Vital 1 🗌 Yes 25 Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ⊠atural 5 Pending death. 2 Accident investigation 1 TYes 2 No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 00060878 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANDALSIDUN BANSAL NIVIDILA 9109 LIBIERI4 Rom 32. Pagistrar's Signature State Registrar

By a rain of a should be med within 72 hours after death with the Mariyian of Health and Mandrell Hygiens. If item 27 is marked other than "natural; or Items 23a or 28a-7 show and the contact reaumatic avant. Ite Madrell Exercites the notified at the contact reaumatic avant. Ite Madrell Exercites the notified at the contact reaumatic avant. Items with the contact reaumatic avant.	al er	Sarah Lohr 4a. Facility Name (If not institution, give Shady Grove Ac 5. Social Security Number 6. S	street and number			Month	Day Yes	41
Funeral Director	er	Shady Grove Ac 5. Social Security Number 6. S	street and number;			May 2	.4 , 2005	7:30 AM
Director		5. Social Security Number 6. S			4b. City, Town, or Location of	Death	4c. County of D	
Director					Rockville		Montgom	
tams 23a or 28a-f show		210-22-13/3	ex 7. Ag ☐ M 21 万 F	90 Yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	Min. (Month, L	irth (9. 1914) 9. 1914	Birthplace (State or Fore Country) uni
tams 23a or 28a-f shoer mary	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Lin
tams 23a or 28a		MD Montgom	ery	Montgom	ery Village			1 ☐ Yes 2√
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tams 2	0	19310 Watkins Ma	ill Circle		20886		USA	
Baf, or	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	in? (Specify Yes or N Puerto Rican, etc.)		merican Indian, hite, etc. white
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Med P	Completed	Elementary/Secondary (0-12)	College (1-4or	life	kind of work done during most DO NOT use retired)	or working		
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avan	Be	17. Father's Name (First, Middle, Last)			unk 18. Mother	's Name (First, Middl	e, <i>Maiden Surna</i> me)	1
and Mental Hygiene. Is marked other than aumatic avant. Ita M.	0			1 72				
Health and the standard standa		19a. Informant's Name/Relationship (Shady Grove Hos		9901	ng Address (Street and Number . Medical Cente	er Drive R	ockville, N	1D 20850
rtmer rtant njury		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify) in state		matory or other place)	Date	20c. Location - City	or Town, State
Depa Impo any ir once.		21. Signiture Funeral Service Licen	Wade, Din	S. S.	Name and Address of Facility tate Anatomy Bo altimore, MD		. Baltimor	e Street
	1	23a. Part . Enter the disease, or companies shock or heart failure. List only	olications that cause one cause on each l	the death. Do not ent ne.	er the mode of dying, such as c	ardiac or respiratory	arrest,	Approximate Interval Between
hysician		Immediate dause (Final disease or condition	a. Seps	is				Onset and Deat
/Medical xaminer		resulting in death)		a consequence of):				I WEEK
		Sequentially list conditions,	bpneu	monia				1 week
ij .	lne	Sequentially list conditions, y each of the mediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	n nunsequanda of):				
and Il-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):			_	
physician and streaming the burial-transit	edicai E		d					
attending p for use as		IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome				23d. Date of	delivery
y the	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		Ectopic pregnancy Other (specify)		Month	Day Year
igned be deta	by T	Part II. Other significant conditions of		-	nderlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death
been sig		urinary t	ract infe	ction		1	Yes 2□No 3□	Probably 4 Unkn
e has bee	Completed	dementia				24a. Wa: auto perf	opsy prior to death	
		25. Was case referred to medical			OF Plans	1 ☐ Yes of Death (Check only		es 2 No
is cert direct	0	examiner? 1 ☐ Yes 2 X No	Hospital: Inpatio	ent 2 ER/Outpatien	0.0		idence 6 Other (S	nac(fr)
th. After thi	Tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	The state of the s		28d. Describe	how injury occurred	Secury
within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	ury - At home, farm, stre c. (Specify)		28f. Location	(Street and Number or wn, State)	Rural Route Number,
within 24 hours after death. To tha Funaral Director: A completely filled in by the funaral filled in by the funaral filled in by the function of the functio	Medical Ce	29a. Certifier (Check only one) 2 Certifying Ph 2 Medical Examone)	iner: On the basis o	f examination and/or inv	occurred at the time, date and restigation, in my opinion, death	place, and due to the	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
thin the sample	Me	29b. Signature and title of certifie	and manner st	180.	29c. License number		29d. Date signed (Mo	nth, Day, Year)
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1	(20 4	C	leath /Itam CC-) T	D0061681			
		Robert Kirkcaldy			·	D==l==111	MD	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:56 PM June 3 2005 heunard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balhimure
If Under 1 Year If Under 24 Hrs. tospital emo rial 7. Age (In rs. last birthday) 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. 1**№** M 2□ F 212-50-1007 Yrs. Director north Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other treumatic event, the Madical Examinations to recipied at 1 ☐Yes 2 ☐ No Director mo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? US 2327 21218 arle Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ontractor 6 mprovens 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be heunard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is n any injury or other treum once. 131UC /irgikia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ F

* 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State run mount 22. Name and Address & Facility
Carlfor C. Vonsters
1701 McCuffor St. 21. Signature of Funeral Service alfor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PSIS day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed use as the burial-transil Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifics funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 0 1 ☐ Yes 2 No 1XInpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident М investigation filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 13 2005 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/East University Parkway Bultimore, MD nunda MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005 I MIN!

Physician Examiner しっているし Funeral Director the Maryland 28a-f show Itams 23a illed within 72 hours after ō Hygiene. Pages 1 and 2 should be f nent of Health and Mental I

event, the Medical Exertinar for must be notified at **PROPRIETOR** 17. Father's Name (First, Middle, Last) Be MYER LEVENSON ANNA 2 19a. Informant's Name/Relationship (Type, Print) FRIEDA LEVENSON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages Department of Important: If it any injury or o once. 1 X Burial 2 □ Cremation 3 □ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Edwara C. Kusu Immediate Cause (Final Physician Discase Arten disease or condition resulting in death) Loronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. àq Division of Vital Records. Be Completed funeral director, page 2 should 1 ☐ Yes 25. Was case referred to medical examiner' Certification: To 1 Yes 2 No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Medical completely (Check only one) To tha within 2 29b. Signature and title of certifie 29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year JERRY LEVENSON 12:50 PM TUNE 13 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death == Hospital Baltins Baltmore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day Yo Birthplace (State or Foreign Country) Days Hours 1 M 2□ F 218-05-3399 91 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6711 PARK HEIGHTS AVENUE #113 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 🕅 No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SHOE STORE 18. Mother's Name (First, Middle, Maiden Sumame) MOLTZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 PARK HEIGHTS AVENUE #113 - BALTIMORE, MD 21215 20c. Location - City or Town, State (ANSHE EMUNAH) AITZ CHAIM 6/15/2005 HALETHORPE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 30 ys 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 X No 1 ☐ Yes 2X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) t 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Itospital Ethernata MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Day,

egistrar's Signature

			1 - For State Registrar	State of Ma	aryland /		rtment of H		_	giene Reg. No. 2	005	20092
	Physici		1. Decedent's Name (First, Middle, La	. ,	MOORE				2. Date of De	ath	005 Year	3. Time of Death 5:40 P M
	/Medio Examin		4a. Facility Name (If not institution, given GOOD SAMARITAN I	re street and number)	11,00.0-		4b. City, Town, or BALTIMO	Location of Death	<u> </u>		unty of Death	3010 2
	Funeral Director		Social Security Number 6.3		(In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year) • 1942		place (State or Foreign htry)
	aryland show	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov		_				1	0d. Inside City Limits
	with the Ma a or 28a-f	Directo	10e. Street and Number	ROAD	BALTII	MUK	10f. Zip Code	0		10g. Citizen	of What Cour	1 X Yes 2 ☐ No
0)	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Items 23a or 28a-f show event, its Medical Exam act must be a willised at	Funeral Director	1324 CROFTON 11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 X Yes 2 N			2123 /as Decedent of Hi Yes, specify Cubar	<u> </u>	pecify Yes or No Display Rican, etc.)	- 14.	USA Race - Americ Black, White,	
21215-0036	72 hours a natural', o	by	3 ☐ Widowed 4 🌠 Divorced 15. Decedent's E (Specify only highest gr		16a	. Decede	☐ Yes 2 ♣ No ent's Usual Occupation of work done of	Specify:	king		of Business/In	<u> </u>
	e filed within all Hygiene. I othar than "I vent, the Man	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use retired,			BETH		EL
Maryland	should be fill nd Mental H imarked off	To Be	17. Father's Name (First, Middle, Last					18. Mother's Nam	TAPSCO	П	,	
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Baltimore,	Page ⊓ent o ant: If ury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)	CROWN	usv, crem USVII	atory or other place LE	06.2	1.05	CROWN	USVILLE	
Ba	permit. Departi Importi any inj		23a. Part1. Enter the disease, or com	4	the death. Do	515	Name and Address IGHN C. C. G. BAUTO. I	NATU PIKE	BALTO.	mu ;	ICE 21229	Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. He d	ed Iv	Ye	vies	, such as cardiac	or respiratory at	1631,		Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions, if any, leading to immediate	b	a consequence							
ó	ficate be executed g physician and is the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	1 consequence	of):					-	
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isio	or Attandii after death. Diractor: A in by the fu	icatio	2 Accident investigatio 3 Suicide 6 □ Could not b	n 6/12/05	- Vou	not	2 M 1 □ Y	es 2 ŽNo	28f. Location (S			NStairs
<u>≥</u>	urs after ral Dirac	Certification;	4 Homicide determined	building, etc Re S	(Specify)	e			13 CEL+	M. State)	374 CI	soften Rd
	To the Hospital or Attanding Physician: The within 24 hours after death. To tha Funeral Diractor: After this certificate his completely filled in by the funeral director, page	ledical	(Check only a Medical Example one)	nysician: To the best of miner: On the basis of and manner sta	examination ar	e, death nd/or inve	estigation, in my op	inion, death occur	red at the time, o	date and plac	ce, and due to	the cause(s)
•	Will Will	Z	29b. Signature and title of certifier	talla	n md	<i>i</i>	29c. License	number CME			gned <i>(Month, 1</i> 13, 200	
1			30. Name and address of person who	LAWN	b		111 P	enn Stre	et Balt	imore	, Mary	land 21201
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1	32. Registra	r's Signature	the figure	pedi					

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of Hertificate of L			ene () ()5	20093
	Physici /Medi		Decedent's Name (First, Middle, Last, Virginia I		Cormick			2. Date of Death	Day 20	Year 305	3. Time of Death
	Examir		4a. Facility Name (If not institution, give		•		Location of Death		4c. County		
			Levindale Hebrew Geria			Baltimo	ore If Under 24 Hrs.	0.0-1-16014		N/A	
	Funeral Director		5. Social Security Number 6. Se 216–16–5817	м 2Д Т	Age (In yrs. last birthday 83 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	1922	Coun	lace (State or Foreign try) Land
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	coation				14	Ord. In side City I in the
	Aaryla f sho	ō	Maryland N/A							''	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-	Funeral Director	10e. Street and Number		Da	1timore		100	2. Citizen of V	Vhat Coun	
	3a or	Ö	1213 Haverhill Roa	ha		21229	a		US		,.
	death	nera	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar		ecify Yes or No-	14. Race	e - America	
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is markad other than "natural", or Itams 23a or 28a-f show or other traumatic avant. The Modical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2; If Yes, Give Year or Date	MΩNο	1 ☐ Yes 2 🕅 No	Specify:	Hican, etc.)	Specify	k, White, 6 Whi	
0-10	72 ho	ted	15. Decedent's Edu	cation	16a. Dece	edent's Usual Occupa	ation	16	Sb. Kind of Bu	isiness/Ind	lustry
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	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)			Homemaker	18 Mother's Name	e (First, Middle, Ma	Own I		
Maryland	ould be i Mental l arkad o	To Be	Unk.				Unk.	5 (1 115t, 1116616, 1116	noon ooman	O)	
ary.	2 should and Men Is marka aumatic	1	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mail	ing Address (Street a		al Route Number, (City or Town,	State, Zip	Code)
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ore,	of He of He fitem roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Disp	osition (Name of omatory or other place			c. Location -		wn, State
<u>E</u>	Pa ant ury	0	'4 □ Donation 5 □ Other (Specify)	temoval from Sta	Metro Cr	ematory Ir	10.06/1.				Mary land
Baltimore,	pernit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lights Thomas Gregor	90	2	2. Name and Addres Cremation 299 Frede	s of Facility 1 Society Prick Roa	Of Maryl	land Ir	nc.	nd 21228
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comply shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	sed the death. Do not er	acception of dying acception of the property o	g, such as cardiac of linfu	or respiratory arres	- 121 - 120		Approximate Interval Between Onset and Death Archary
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d3c. If yes, outcome 1 □ Live birth	me of pregnancy 1 2 Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date Mor	e of deliver	ry Day Year
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		othe Othe	26. Place of Death				
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27. Manner of Death Continue Check only one) 29b. Signature and title of certifier 29c. Land and manner stated. 29								28f. Location (Stree City or Town, S		er or Rural	Route Number,
	ha Hospit n 24 hour ha Funare	Medical C	29a. Certifier (Check only one) 1 Certifying Phylogenesis Certifying Phylogenesis Certifying Phylogenesis Certifying Phylogenesis Certifying Phylogenesis Certified Phylogenesis Certi	sician: To the be ner: On the basis and manner	est of my knowledge, deal s of examination and/or in stated.	th occurred at the tim nvestigation, in my op	e, date and place, a inion, death occurr	and due to the caused at the time, date	se(s) and mar and place, a	nner as sta ind due to	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	Λ Λ		29c. License	number	29d	. Date signed	(Month, E	Day, Year)
)	0		Meyen	· pur		DY	4817	yr.	ine l	574	2005
est.	1		30. Name and address of person who co	mpleted cause of	of death (Item 23a) (Type 2434 W B	Print) el velere	ane 1	3alkin.	re	Med	21215
	Sta Registr		31. Date filed (Month, Day Year)	05 32 legi	istrar's Signature	code					

Mccormick Virginia

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #26 PER VERB C8 Gertificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Elizabeth Mertz Month Year **Physician** June 10, 2005 17:08 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Beltsville Prince Georges 13109 Greenmount Ave. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 10M XF 222-14-3077 77 20.1928 Delaware **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at 1 Yes 2 □ No Brevard West Melbourne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Marnie Circle 32904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "n eny injury or other traumatic event. Its Meat once. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Petrucci Jennie Velecci 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Miller/Daughter 13109 Greenmount Ave Beltsville MD 20705 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Balt. Wash. Crematory 6-14-05 Laurel. MD 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7601 Sandy Spring Rd. Lawrer, MD 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MIEIESTATIC Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, lany, sand list immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a const uence of The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 🗆 No 2 No 1 ☐ Yes 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) DAUGHTER"s examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Total dence 6 XX her (Specify) RESIDENCE 2 1 Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptile 11 200 BELTSULE DRIVE, BUTS WILL WY pleted cause of dea 1 Item 23a) (Type, Print) 30. Name and address of person who SHIAUAUMS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 6 2005 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrer			nd / Depa		of H	ealth a	and Mental H			20095
			1. Decedent's Name (First, Middle, L	ast)						2. Date of D		- V 1/	3. Time of Death
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	ırylan show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Ba-f s	Director	MD n/a		Ba1t	imore							ty⊟XYes 2 No
	with th	Dir	10e. Street and Number				10f. Zip C				10g. Citiz	en of What Co	untry?
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Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23a or 28e-f show The Madical Evandrar must be motified at	by Funeral	1 ☐ Never Married 3☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2[No e		f Yes, specif		Specify:	gin? (Specify Yes or N , Puerto Rican, etc.) white	1	Black, White Specify.whi	e, etc.
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and	Q 5 0 0	Be c	Charles Henry Me	•						r's Name <i>(First, Midd)</i> a Dah1	e, Maiden S	Sumame)	
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	and 2 : ealth ar n 27 is ier treu		Robert Mryncza-	Husband						Baltimore,			
Jre,	oth oth		20a. Method of Disposition	¬		Place of Dispo semetery, crer	sition (Name	of ar place)	Date	20c. Loc	ation - City or	Town, State
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Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Ice	nsee						Loudon Pa			
	20599		MIN DU	Wang	pul					BAltimor		ryland	
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on	Attending Phy r death. ector: Atter thi by the tuneral o	tlor	1 Datural 5 Pending 2 Accident investigation		h, Day Year)	Injury	м	Work'	? es 2∐N		,,		
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	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely tilled in by the to	edical	29a. Certifier 1 Sertifying P (Check only one) 2 Medicel Exe	miner: 🙉n the ba	isis of examinat	wledge, death tion and/or inv	occurred at restigation, in	the time my opi	e, date and nion, deat	place, and due to the h occurred at the time	cause(s) a date and p	nd manner as solace, and due t	stated. to the cause(s)
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	, 1		30 Name and address of person who	gompleted caus	of death (Item	1 2 23) (Type,	Print)			1 11		17	2
	4		Jaul Casym.	184 9	00 1	ato	HA	re	- 1	Scaltimur	re VI	10 2	21229
	Sta	-	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ture							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** ALVIN MITCHELL, SR 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE, WO ANNE ARUN ARUNDEL HESPITAL GLEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1∏M 2□F **Funeral** Days Months Hours Director JUNE 30, 1921 218.14.4383 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Evantral must be notified at 1 ☐ Yes 2 ☐ No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1585 DULANEY LN 21060 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XXYes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: WH<u>ITE</u> Baltimore, Maryland 21215-0036 Specify 3√Widowed 4 □ Divorced Year or Dates: WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WELDER STEEL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LAYTON LARRY W. MITCHELL Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 611 NEW JERSEY AVE NE GLEN BURNIE, MD21060 SON item 27 i JEFFREY G. MITCHELL other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition o <u>=</u> 1 Burial 2XXCremation 3 Removal from State ö permit. Page Department o Important: If any injury or ' 4 □ Donation 5 □ Other (Specify) BAYVDEW CREMATORY INC 6.13.2005 BALTIMORE, MD 21. Situation of Funeral Service License K. GREGOXY FINK 22. Name and Address of Facility
FINK FUNERAL HOME PA
426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. MO1148 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TAROM BO EM BOLISM

Due to (or as a consequence of): **Physician** /Medical Examiner COA GULU PATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2' ANICH OF BURDER CHRONIC STRIAL FIBRILLA TON 10 Yes 2 No 3 Probably 4 Unknown HEART FRICURE CARDUIL OBSTAUL- 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No TIVE PULLBNARY DISERSE 2 □ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20041284 Karmen

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMUNDO

JUN 1 6 2005

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene [] [] 5

For State Registrar Certificate of Death

Physician /Medical **Examiner**

Funeral Director

filed within 72 hours after death with the Maryland r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be nutified at Is marked other than Pages 1 and 2 should be filment of Health and Mental Hant; If item 27 Is marked ot

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

permit. Page Department o Important: If any injury or once.

burial-tran attending physician the detached signed by peen has certificate After this the funeral within 24 hours after To the Funeral Dire

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JÜNE 2005 3:30 P.M **ELLA** VIRGINIA NASUTA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE PARKVILLE 8322 EDGEDALE ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 2/10/1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 M 2 XF 212-44-2954 Yrs. MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE PARKVILLE 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8322 EDGEDALE ROAD USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Yes, Give ear or Dates: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 9TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELLA LAVINA HOWES CLAUDE RAYMOND GRIMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8322 EDGEDALE ROAD PARKVILLE, MD 21234 JAMES STANLEY NASUTA/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State CRESTLAWN CEMETERY 6/20/2005 1 4 ☐ Donation 5 ☐ Other (Specify) MARRIOTTSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH FAVEN BLVD. TOWSON, MD ANI. Enter the disease, or complicitions that dised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDUMDIN NEGRETION Due to (or as a consequence of CURUNMY BILIENY D1515/151 Sequentially list conditions, if any, leading to infimodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 [] Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown BRUNCHIEZMASIS Completed CIMONE USSMUCTIVE PULMURMY DI 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15135 June 15, 2005

Registrar

State

X

5701

. Registrar's Signature

WIGH NAVEN SLUD, SATTMONE, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. SWITMD

PENGLUNG

31. Date filed (Month, Day, Year)

JUN 1 6 2005

			1 _ State	State of Maryland / [-	rtment of H				05 20098	R
			Registrar 1. Decedent's Name (First, Middle, Last)		0011	incate of L	Jean	2. Date of Dea	ith	3. Time of Death	<u>J</u>
П	Physicia			LIVAN				June	Day	Year 3:30 PM	
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Dea		4c. County	of Death	
			UNION MEMORIAL			BALTIMO				1 A	
	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yrs. last bit	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		(, Year)	Birthplace (State or Foreign Country) MD)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Loc	ation				10d. Inside City Limits	
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	th wit		6570 ST. HELEN	IA AVENUE		2123	22			ISA	_
	ar dea	Funerai	11. Walter States	2. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗗 No If Yes, Give Year or Dates:	1	□Yes 2 ⊠ -No	Specify:		Specify	WHITE	
21215-0036	J within 72 hours after death with the Maryland jiene. r then "naturel", or Itams 23a or 28a-1 show Its Mucheel Examiner must be notified at	ted	15. Decedent's Educ	ation 16a		ent's Usual Occupa		anderina on	16b. Kind of Bu	usiness/Industry	
215	thin 7: en "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	rind of work done of O NOT use retired	ouring most of we	onking	T0	_	
	filed with Hygiene. Ither ther	Соп	12 TH GRADE	NA		COOK	40.14-4-4-1-11-	(F) - 1 A 6 4 4	FOOI		
Maryland	ed tal	Be	17. Father's Name (First, Middle, Last) CHARLES MATIER					me (First, Middle, M - BRO		18)	
II Y	s 1 and 2 should ba f Health and Mental item 27 Is markad o other treumetic eve	은	19a. Informant's Name/Relationship (Typ	e, Print) 19t	o. Mailing	g Address (Street a		lural Route Numbe		State, Zip Code)	_
	무속 C T		TONIA SWEITZER	65	510	ST. HELEN	JA AVE.	, BALTO.	αM	21222	
Jre,	of Head		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	cemete	of Dispos	ition (Name of atory or other plac		Date	20c. Location -	City or Town, State	
Ē	Pages ment of ant: If its ury or o		'4 □Donation 5 □ Other (Specify)	GREEN	IMO	UNT	06.	16.05	BALTO.	MO	
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service License	·I	CRE	Name and Address MATION SE DIBAUD, NA	ERVICE	3AUTO MO	21229		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death. Do						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Chronic Obs		_				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):		/			100	
Н	- Laminer	er	Sequentially list conditions,	Due to (or as a consequence		Failue				18 years	_
	itad I	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Longs tire It		Failure Failure				18 40015	
Ć.	be executad sician and burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):	20,0	, ,			= 12.5%	
8760	The law requires that the death certificate be executed at the seen signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d								
9	ing ph	Med	IF FEMALE:	: 11			- 111				
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death		Ectopic pregnancy	,			te of delivery onth Day Year	
0	that the de ned by the a detached f	ysic	1 ☐ Yes 2 ☎No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5□	Other (specify)					
0	ires that t signed by d be detai	y Ph	Part II. Other significant conditions con	tributing to death but not resulting	in the un	derlying cause give	en in Part I.	23e. Did to	obacco use cont	tribute to the cause of death?	
rds,	quires in sign uld be	ed by						1 🗆 Y	res 2□No	3 Probably 4 Unknown	ì
Record	aw requir is been si 2 should	Completed						24a. Was		Were autopsy findings available prior to completion of cause of	э
R	The law ate has page 2	Com						perfo	rmed?	death? 1 ☐ Yes 2 ☐ No	
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					eath (Check only o	ne)		_
of \	Physicien: this certific ral director,	0	1 ☐ Yes 2 PNo	ospital: 1 Inpatient 2 ER/O	utpatient Time of	t 3□ DOA Oth	-4 Lindishing	Home 5 Resid	dence 6 Oth		
UC.	ding f	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Injury	Wor	yai k? Yes 2∐No	200. Describe i	iow injury occur	180	
Division	l or Attendii after death. Director: A in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, f	arm, stre			28f. Location (5	Street and Numb	ber or Rural Route Number,	
Ö	s after of Directory	Certification;	4 Homicide	building, etc. (Specify)				City or Tox	vn, State)		
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medicai (ician: To the best of my knowledger: On the basis of examination a and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	10		29c. Licens	e number		29d. Date signe	ed (Month, Day, Year)	
	0/1		Ellet &	Have Do		11006	1180		June	13, 2005	
	2		30. Name and address of person who co	mpleted cause of death (Item 23a)) (Type, I	Print)				. 0 -	
			Elliot Share I	20. 20 Fast	un	iversity	Forting	1 Belly	more, M.	13, 2005 2005	5
* -	St Regist	ate rar	St. Date med (worth, Day, 19al)	6 2005 Mesus	X.	Specie					
		2									

DHMH 17 Rev 1/2001

2005

MAYME OXENDINE

		•	For State Registrar	State of Ma	aryland		artmen tificate					giene Reg. No.	005	20101	0
	Physicia		Decedent's Name (First, Middle WILLIAM	e, Last) LEROY		OWING	lS				2. Date of De Month JUNE	nath Day	2005	3. Time of Death 1:45 P.	Л
	/Medic Examin		4a. Facility Name (If not institution RUXTON HEALTH		ГТАТТС	N			Location of			4c. County of Death BALTIMORE			
	Funeral Director		5. Social Security Number 217-26-3611	6. Sex 7. Ag	e (In yrs. la: 79		If Under Months		If Under Hours		8. Date of Bir (Month, Da 7/31/1			place (State or Foreig htry) LAND	ın
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							Od. Inside City Limit	
	the Ma 28e-f s	ector	MD BALT:	IMORE		DUN	IDALK 101. Zip	Code				10g. Citizo	en of What Cou	1 Tes 2 No	
	th with 23e or	al Dir	1947 FRAMES RO	OAD				21222	2			US			
920	within 72 hours after death with the Maryland ane. than "netural", or Items 23e or 28e-f show fra M. Jigal Examiter must be matified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yas Giva		1	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:					14. Race - American Indian, Black, White, etc. Specify: WHTTE			
21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. Id other than Instural', or Items 23e or 28e-f show event, I're Madical Examiner out the natified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12TH GRADE	nt's Education st grade completed) College (1-4or 5	5+)	16a. Deced (Give life.	kind of wor DO NOT us	k done a	luring mos	t of workin	ng	LEAGU		Business/Industry OF THE CAPPED	
Maryland 2	should be filed withir nd Mental Hygiene. marked other than matic event, IT's M.	To Be C	17. Father's Name (First, Middle, WILLIAM OWING	GS	•				VIO	LA SA	(First, Middle				
Mar	nd 2 sho Ith and 27 is m r traum		19a. Informant's Name/Relations SANDRA NEIKIRK				ng Address FRAME				I Route Numb IMORE ,	-	Town, State, Zi _l . 2 1 222	Code)	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es	- Total Control	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 ☐Removal from State		ce of Disponetery, crer	esition (Name matory or o	ne of ther place PARM	g)	6/17,	/2005	20c. Loc	ation - City or To	MD	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service	/ Vey		8	521 L	OCH	RAVE	N BL	D. TOW	SON,			
	Pnysician /Medical		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aG as *	ne. o int	es h'n				cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
b	Examiner			Due to (or as	a conseque	ence of):									
٥,	e be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as											
8760,	cate be ex physician a the burial	edicai		d.									-		
.O. Box 6	ne death certif the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal c	leath 3	Ectopic pr Other (sp					23	3d. Date of delive Month	ery Day Year	
Ω.	sign sign d be	þ	Part II. Other significant condition Periphera (_		_	nderlying c	ause give	en in Part I	l.		robacco us Yes 2		he cause of death? pably 4 🔟 know	n
al Records,	The ate ha	Completed									24a. Was auto perfo		prior to co death?	psy findings available mpletion of cause of 2 No	ө
f Vital	Physicien: this certific ral director,	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	ent 2 E	R/Outpatier	nt 3 DC	Othe			n <i>(Check only</i> only only only only only only only only		□Other (Specil	y)	
on of	ling After une	tion:	27. Manner of Death 1	28a. Date of Inju (Month, Da igation	iry y Year)	28b. Time o Injury	f 2	8c. Injury Work		2	28d. Describe				
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of In	ury - At hon c. (Specify)	ne, farm, str			-	-	28f. Location (City or To		Number or Rura	al Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis o and manner st	of examination		vestigation	, in my or	oinion, dea			date and p	place, and due to	the cause(s)	
	withi To th	S	29b. Signature and title of certific	Balrit,	u,p.				o number	676			signed (Month,		
6			30. Name and address of person (aren C. Ball	who completed cause of	death (Item)	23a) (Type,	Print)			-			,		
	Sta Registi														

DHMH 17 Rev 1/2001

		1	State Registrar amend item		laryland / Dep				giene Geg. No. 005	20101
			Decedent's Name (First, Middle, La	st)	er in gora	U/ LU/ U/	/11	2. Date of Dea		3. Time of Death
	Physicia /Medic	_	Joseph Macion 1	Phon AS				JUNE	11,200	
	Examin		4a. Fecility Name (If not institution, giv		;)	4b. City, Town, o		ath	4c. County of D	eath
			Union MEAUXIN	Huspital	· · · -	BAHI			Ma	
	Funeral		5. Social Security Number 6. S	Sex. 7. A	ige (In yrs. last birthday) Yrs.	Months Days	Hours M		h (, Year) 9.	Birthplace (State or Foreign Country)
	Director		SUG- 36-368/ Usual Residence of Decedent		81					
	yland now		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	B-f st	to	MO Na		Baltimo	RE				12 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	rai	4804 NURTON A			21215			U.S.A.	
		nne	11. Marital Status	12. Was Deceder Armed Forces	5?	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexica n , Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc.
36	hours after death with the Marylan jurel', or Items 23a or 28a-f show at Examinar must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ¶ If Yes, Give Year or Dates	`	1□ Yes 2 No	Specify:		Specify:	1000
21215-0036	ğ 5 3		15. Decedent's E	ducation	16a, Dece	edent's Usual Occup	pation		16b. Kind of Busine	JACK ess/Industry
212		Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4o	(Give	kind of work done DO NOT use retire	during most of v d)	working .	4	/
21	filed within I Hygiane. other than "	E O	6	0	As	sphalt n	IKER		Asphul	+
nd	0 2 2 5	Be (17. Father's Name (First, Middle, Last)				lame (First, Middle,		
y la	should be ad Mental marked o metic eve	ပ	Edward Phomos					NCE GR		. 7
Maryland	2 s 9 0 0 0		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	33.5			City or Town, Stat	
	1 and Health em 27		MALY THUMAS 20a, Method of Disposition		20b_Risco of Dieg	g Nukto Asitis a (N amasaka)	PUT CIT	BAHMURE		
Baltimore,			1 Burial 2 Cremation 3 C		Cundes will	Church Clar 5.6.C. & 9-10		118/05		NER, SC 29461
ıltin		Ì	21. Signature of Funeral Service Lice	•		22. Name and Addre		0/	need Hon	
Ba	permit. Departrimporte any inju		(Yatrinia B	etts	in the second			-	timus MD	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each	ed the death. Do not er					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	ACF	IRATI	ON P	NEL	1190NI	A	Onset and Death
7	/Medical		resulting in death)	u	as a consequence of):			[/ []		- WEEN
	Examiner		Sequentially list conditions.	b. —						
9	pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):					
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):				0.04	
8760,	cate be executed obysician and the burial-transit			,						
687	8 5 5	edical		Q						
Вох	eath certifii attending p for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Estable program			23d. Date of	•
B	death	icla	in the past 12 months?		at time of death 5	□Ectopic pregnanc □ Other (specify) _	У		Month	Day Year
P.O.	at the de by the	by Physiclan/Me	9 Unknown							
Ś	es tha igned be del	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.			te to the cause of death? Probably 4 Junknown
Vital Records,	v require been sig should b	Completed						-		
ec	e law has b je 2 sl	nple						24a. Was	an 24b. Were prior med?	e autopsy findings available to completion of cause of h?
E	ysicien: The is certificate hadirector, page								2 No 1	Yes 2 No
VIII.	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot		Death (Check only o		- 4
of	Phys rthis ral di): To	1 Yes 2 No	28a. Date of I	atient 2 ER/Outpatie	of 28c. Inju	ry at		dence 6 Other (s	Specify)
OU	nding th. : Afte s fune	tlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year) Injury	Wo	rk?]Yes 2 □ No			
Division of	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not determine	4 280. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (S City or Tov	Street and Number o	r Rural Route Number,
Ö	al or s afte	Certification:	4 Homicide	bullding,	етс. (Зреспу)			City of 104	WI, State)	
	ospit hour unere ly fille	cal	29a. Certifier 1 ☐ Certifying F	hysician: To the be	st of my knowledge, dea of examination and/or i	th occurred at the ti	ime, date and pl	ace, and due to the	cause(s) and manne	r as stated.
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending prompietely filled in by the funeral director, page 2 should be detached for use as	Medical	one)	and manner	stated.					
	with To Con	2	29b. Signature and title of certifier	1111.11.	MI	29c. Licen			29d Date signed (M	
	· h		Over	- COUNTRA	_4	0	1110	3	VVIVE	11,2005
	1		30. Name and address of person who	completed cause of	death (Item 23a) (Type	2015	INAN	1 DUN	IAL DI	TAMANAR
	C+	ate	30, Name and address of person who	₩. Regi	strar's Signature	WI E.	UN	V. ITRO	(, 13/12	MO LIZIE
	Regist		31. Date filed (Month, Day, Year)	105	strar's Signature	ME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4,2005 12:58PM JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore 10901 a Gamaritan If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours 87 Yrs. 29-05-526 Director 261 Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23e or 28e-f show other traumatic evant, the Medical Examination intail be routified at Baltimore 1 Pres 2 □ No Completed by Funeral Director MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 1336 Meri Drive 21239 USA dene 2 should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kallroad ocometive Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthoni Yanosczy K ٩ 19a. Informant's Name/Rulationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State - Mountain Δd 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any njury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 6/18/05 Ascension * 4 ☐ Donation 5 ☐ Other (Specify) Mocanaqua Ceneter 22. Name and Address of Pacility Joseph 2222 W. North L. Russ F/H, PA 21. Signature of Juneral Service Licenses 3 altimore Avenue 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Registan Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit The faw requires that the death certificate be executed that initiated swante resulting in death) Last Due to (or as a conse y ence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by cate has been signed page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Hospital or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 页 Mo Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fun completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar 1ZUKAN 1 SI 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Anthony

5601 LOCHRAV

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keg 000

Boulevard, Balti

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Loo5 Month **Physician** 43-117 lare Lune /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Health Care-Harford Baltimore NA Harborside If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) _oFuneral 1 M 2 1 F Months Days 232-34-0153 Director 116/25 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23a or 28e-f shorthe Medical Examiner must be notified at 1 Yes 2 No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4520 View Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 100 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home awin Home ma Ker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patterson Effic ္ဌ marles Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Department of Health a Important: If item 27 is eny injury or other tre 2031 Featherbed (Daughter) Delores hane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 6/16/65 Woodlawn, MD 4 Donation Memorial tark 21. Signatur 1 F neral Service Licensee 22. Name and Address of Facility Joseph L. RUSS FIH. PA 2222 W. North Avenue Batto, MD 21216 23a. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Gne The law requires that the death certificate be executed attending physician and I for use as the burial-transit Physician/Medical Examlr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): ate has been signed by the a page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yes 2 No 2/2 10 1 ☐ Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No é ☐ Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2005

and manner stated.

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 / Loch Raveu

ignature

Division of Vital Records, P.O. To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

> State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Dav.

			1 - For State Registrar	State of Maryla			Health and		_	5 20104
Н	Physici	an	Decedent's Name (First, Middle, Last	,				2. Date of Death Month	Day Yes	3. Time of Death
	/Medic Examir	al	Theodore R. Ray 4a. Facility Name (If not institution, give Washington Adver	,	.1	4b. City, Town, Takoma	or Location of Dear	June 6	4c. County of D. Montgom	
	Funeral Director		5. Social Security Number 6. S 218–76–7435	-	rs. last birthday) 35 Yrs.		If Under 24 Hrs	(Month, Day,		Birthplace (State or Foreign Country) [ashington, DC
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Montgome:		City, Town or Lo Silver					10d. Inside City Limits
	or 28c	Direc	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	s 23e	ral	8222 Tahona Dri		110	20903				ISA
036	ours after de ral', or Itam Examinar o	by Funeral Director	11. Marital Status 1.★ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other traumatic avant. I're Medical Examiner must be notified at ODGe.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire sic Teach	during most of wo ed)	rking 16	Sb. Kind of Busine	
yland ;	ould be filed Mental Hyg arkad otha atic avant,	To Be C	17. Father's Name (First, Middle, Last) Theodore R. Ray,					me (First, Middle, Man n Brooks	aiden Sumame)	
	and 2 sho saith and n 27 is m or traum		19a. Informant's Name/Relationship (7) Theodore Ray, Jr.					ural Route Number, (Arlington,		
Baltimore,	Pages 1 and of He Int. If Item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crei	osition (Name of matory or other pla		Date 20	oc. Location - City	or Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licen		38	2. Name and Address 31 Georg	ess of Facility ia Ave.,	Latney's F	uneral Do	lome 1 Inc.
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	olications that caused the done cause on each line. a. Due to (or as a cons	eath. Do not ent	^	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death 5 Vays
3760,	ate be executed thysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons d.	sequence of):					
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preductions of the second of the	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of c	delivery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions on	ontributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.			to the cause of death? Probably 4 Dunknown
Records,	he law requir e has been si ige 2 should	Completed	olilrity	.1				24a. Was an autopsy performe	prior to death	
	yelcian: The is certificate hadirector, page	Be Co	25. Was case referred to medical examiner?	1014sis			26. Place of Dea	1 ☐ Yes 2☐ ath (Check only one)	Ho 1□Y	es 2 No
Division of Vital	Attending Phyelcian: ar death. actor: After this certifica by the funeral director, p	ပ္	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year,	ER/Outpatier 28b. Time of Injury	f 28c. Inju	ry at	lome 5 Residence		pecify)
Divisi	in Direct	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm, str ecify)		Yes 2 □No	28f. Location (Stree City or Town, S		Rural Route Number,
	H 424	edical C	29a. Certifier 1 Certifying Phyone) 1 Medical Example 2 Medical Example 2	ysician: To the best of my k niner: On the basis of exam and manner stated.	knowledge, death ination and/or in-	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the caus irred at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licens	se number	29d	Date signed (Mo.	nth, Day, Year)
	0		* William Cl	low		D	00 001		6/Le	105
1)		30. Name and address of person who o	completed cause of death (III	tem 23a) (Type,	Print) All AVF	7010	ma Prost	2 MA	209 iA
	Sta Registr	_	31. Date filed (Month, Day, Year)	completed cause of death (II	nature	Goods	1000			

JET Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04057 State of Maryland / Department of Health and Mental Hygiene Bernard Robinson For Stete Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Robinson June 14 2005 8:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 2036 McCulloh Street 8. Date of Birth (Month, Day, Feb. 19 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12M 2□F Months Yrs. 213-34-8110 Usual Residence of Decedent Director 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ZYes 2 □ No Director Baltimore MD NIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 ST USA Itams 23a 2036 ulloh Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printing Co. Printer 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 900g. Be Louis Smith Robinson Lillian 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson - wife 2036 McCulion St. Baltimore, mo alair Bertha 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 □ Cremation 3 □ Removal from State W-20-05 ^ 4 ☐ Donation 5 ☐ Other (Specify) Western Cemeter Baltimore, mo 62. Name and Advess of Facility
Gory P. March Funeral Home P.A.
270 Fredhilton Pass Balto mo 21229 21. Signature of Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Athenoscientic Carchovascular ouses se Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): attending physician Box 68760, Physiclan/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9☐ Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: ¥ Yes 2□ No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending 1 Natural death. 1 Tes 2 🗌 No investigation Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitel 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one)

within 2

State Registrar 31. Date filed (Month) 6 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street 32 degistrar's Signature The second

and manner stated.

29c. License number OCME

29d. Date signed (Month, Day, Year)

June 14 2005 Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item I per phy 2844 6-16-05 vt.

State of Maryland / Department of Health and Mental Hygiene amend item #19a&b per fh g844 6/22/05 Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month JUNE Day O3 2005 10:33 AM Renaldo Robinson Sr. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death BAltiMORE LOSPITAL If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) Hours XXM 2□ F Days 47 Director 217-66-6920 ΜĎ Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits treumetic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23g Funeral 7316 Inwood Ave 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√☐ No If Yes, Give* Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 🏃 🦼 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black 'neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: If fem 27 is marked other the any injury or other treumetic event, Inc. 2005. Correctional Officer State of Maryland 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Deborah Campbell Lawrence C. Robinson 19a. Informant's Name/Relationship (Type, Print)
Sharon Robinson-Sister Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7315 Inwood Ave, Catonsville, Md 2122 Inwood Ave, Catonsville, Md 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 6/10/05 Arbutus, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End stage renal disease uedrs /Medical Due to (or as a consequence of): Examiner Pulmonary one Due to (or as a consequence of): cerebra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1, Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Certification: To 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDPhD Mann RES - 000 JUNE 03,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAO NGUYEN, MOPAD, JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MD 21287

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month,

JUN 1 6

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			For State Registrar	State of Ma	iryland / l	Department Certificate			entai Hy	giene 🤍 🔾 🦠 Reg. No.	J 6	.0101
	Physici	an	1. Decedent's Name (First, Middle, Las.)					2. Date of De Month	Day	Year	3. Time of Death
	/Medio		MARY JEAN RIDDLE 4a. Facility Name (If not institution, give	street and number)		4b, City, T	own, or Lo	ocation of Death	JUNE	13 → 4c. County o	005	11 113
	Exami	ler	NORTH ARUNDE	1 ^	Aı	GLE	-	BURNIE		ANNE	Λ	UNDEL
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last bii	rthday) If Under 1	Year I	f Under 24 Hrs.	8. Date of Bir	th		ace (State or Foreign
	Director		214.56.0239 Usual Residence of Decedent	□ M 2 XX	54	Yrs.			AUG 3,	1950	ML) ·
	land ow		10a. State 10b. County		10c. City, Tow	n or Location					10	d. Inside City Limits
	Many 9-f sh	ţċ	MD ANNE ARUN	IDEL	GLEN B	URNIE						1 Yes XX No
	th the	Director	10e. Street and Number			10f. Zip (10g. Citizen of W		ry?
	ath wi	rai	1810 SAUNDERS WAY				061			US		
	er de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2XX		13. Was Decede If Yes, specif	ent of Hisp fy Cuban,	anic Origin? (Spec Mexican, Puerto P	cify Yes or No lican, etc.)	14. Race Black	- America , White, e	
336	irs aft	by F	3 XVVidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	XX ^{No}	Specify:		Specify:	WHI	TE
9	be filed within 72 hours after death with the Maryland tal Hygiene. In Other then "natural", or Items 23a or 28e-f show event, the Medical Examinat instal be ricilified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a	. Decedent's Usual	Occupation dur	on ina most of workin	a	16b. Kind of Bus	iness/Indu	ustry
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anc	d be fi	Be c	JOSEPH GILBERT M	LLER, SR.			'			WILLS	'/	
~ <u>F</u>	shoul nd Me mark	2	19a. Informant's Name/Relationship (7		196	o. Mailing Address ((Street and	d Number or Rural	Route Numb	er, City or Town, S	State, Zip (Code)
(7) R	and 2 alth a 27 is		MELISSA KLUCZYNSI	KI DAUGH	TER 1	810 SAUN	DERS	WAY GLEN	BURNI	E, MD 21	061	
RIDDLE, MARY Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 Burial 2 X remation 3 4 Donation 5 Other (Specify		BAYVII	of Disposition (Name	e of ORY	6.15.	2005	20c. Location - C		
alti 🗡	permit. Departm importe any inju		21. Signature of Funeral Service Licen	500	·	FINK FU	NEKAL	of HOME, P	.A.			
ω.	89 11 18 18	W 9	K. GREGORY FI		1148	426 CRA	IN HW	Y SW GLE	N BURN	IE, MD 2	1061	
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68760,	tificate b g physic as the b	edicai		d								
	ding p		IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date	of deliver	
Box	that the death cer ed by the attendir detached for use	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at	2 🗌 Fetal death	n 3 □Ectopic pre 5 □ Other (spe				Mon		Day Year
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	Attending Physicien: The law requires that the death cert reath. sctor: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use.	Completed by Physician/N	Part II. Other significant conditions co	ontributing to death bu	ut not resulting i	in the underlying ca	use given	in Part I.	23e. Did	tobacco use contril		
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Vita	ysicien: Th is certificate director, pag	Be	25. Was case re erred to medical examiner?	Hospital:	0.000		Other	6. Place of Death			. (0:6:)	
ð	Phys or this oral di	To tr	1 Yes 2 No	1 ⊿ Inpatie	y 28b.		lc. Injury a Work?	4 Indising non		idence 6 Othe how injury occurre		
jon	nding ath. r: Afte	atio	1 → tural 5 □ Pending 2 □ Accident investigation		rear)	Injury M		s 2 🗆 No				
Division of Vital Records,	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	ury - At home, fa	arm, street, factory,	office	2	8f. Location (City or To	Street and Number wn, State)	r or Rural	Route Number,
Q	urs aft			<u></u>								
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examone)	ysician: To the best of liner: On the basis of and manner sta	examination ar	e, death occurred a nd/or investigation,	it the time, in my opin	date and place, a aion, death occurre	nd due to the d at the time.	date and place, ar	nd due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	5/0		29c.	License n		_	29d. Date signed		
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	Physicia. /Medic			Dolores M. Rallo			June	1 ² 4 ^y	2005	2:00 A M
<i>\</i>	Examin		4a. Facility Name (If not institution, give			Location of Death			inty of Deeth	
			Howard County Ger	_	Columbi	a If Under 24 Hrs.	8. Date of Birth		oward	Jana (State or Foreign
1	Funeral Director		5. Social Security Number 216 34 0766 Usual Residence of Decedent	TH 37 5	Months Days	Hours Min.	July 6	Year)	7 Mar	place (State or Foreign http:) yland
	hand ow		10a. State 10b. County	10c. City, Town	or Location				1	0d. Inside City Limits
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	h the	Director	10e. Street and Number		10f. Zip Code		1	l0g. Citizen	of What Cour	ntry?
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036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel" or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:	
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lan	2 sho and I Is mu		19a. Informant's Name/Relationship (Mailing Address (Street a					
	1 and Health em 27 other tr		Salvatore V. Rall		982 Brookwoo		.llcott		on - City or To	
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 3 □		Disposition (Name of y, crematory or other place				•	
Ë	tmen tent: jury		`4 ☐ Donation 5 ☐ Other (Specify	<u> </u>	ine Park Cem		′ - 2005		imore,	
Bal	permit. Pages 1 and Department of Health Importent: If item 27 sny injury or other tr once.		21. Signature of Funeral Service Licer	Note 101044	4112 Old C	olumbia P	ike Ell	icott		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications to the caused the death. Do none cause to each line. a	Erythen	g, such as cardiac c	or respiratory are	est,		Approximate Interval Between On: t and Death
760, <	te be executed ysician and burial-transit aburial-transit abur	cal Examiner	Samentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence of d.						
68	ntifical ng ph as th	Medi	IF FEMALE:					1		
P.O. Box	that the death certificate ed by the attending phys detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify) _			23d.	Date of delive Month	ery Day Year
	Se Go	d by P	Part II. Other significant conditions of	contributing to death but not resulting in	n the underlying cause giv	en in Part I.	23e. Did to			he cause of death? pably 4 []Unknown
ecol	law requiras as been si 2 should l	piete					24a. Was a autop	sv	prior to co	psy findings available mpletion of cause of
H	sician: The law s certificate has t irector, page 2 s	ПO					perfor	med? 2 XNo	death? 1 🗌 Yes	2€ No
/ita	cian: ertific sctor,	Be (25. Was case referred to medical examiner?		011	26. Place of Deat	h (Check only o	ne)		
)¢	ding Physician: The In. After this certificate hat funeral director, page	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Ou	The same of the sa	4 Nursing no				(y)
n	ding P. After funera	ion:	27. Manner of Death 1 Natural 5 □ Pending	(Month, Day Year)	Time of 28c. Injur njury Wor	yat k? Yes 2 □ No	28d. Describe h	low injury or	scurred	
Division of Vital Records,	al or Attending F s after death. Il Director: After id in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	6 390 Place of Injury At home to		163 2 110	28f. Location (S City or Tow		umber or Run	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical Ce	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Exer	nysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	e, death occurred at the tir d/or investigation, in my o	me, date and place, pinion, death occur	and due to the cred at the time, c	cause(s) and date and pla	d manner as s ice, and due t	steted. o the cause(s)
	ithin i	Med	29b. Signature and title of certifier	COL	29c. Licens	e number		29d. Date si	igned (Month,	Day, Year)
	F 3 F 8	Ī	1/50Hor 1/10	Minnie Jui	D-	36246		June	14, 2	005
			30 Name and address of person who	completed cause of death (Item 23a)		`				
	1		Robert W. Olyine	MD 115 Roesle	- Rel Glen	Burnie,	MD	2101	60	
	St: Regist	ate rar	31. Date filed (Month, Car Year) 6	2005 32. Segistrar's Signature	Specker	V)		, - ·	-	

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryl	and / Depa		lealth and I	Mental Hygie	ene . No 2 () () ()	2010
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Las	ollins	oct tochrace	190. City, Town, o	r Location of Death	2. Date of Death Month	Day Year 7005	Shw
Funeral Director		Usual Residence of Decedent	□M 25€F 64		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		Athplace (State or Foreign ountry)
with the Maryla B or 28a-f show	Director	10a. State 10b. County MD Baltimo: 10e. Street and Number 8713 Richmond Ave	ce	City, Town or Lo	e 10f. Zip Code	1234	100	g. Citizen of What C USA	10d. Inside City Limits 1 ☐ Yes 2 ☐ No ountry?
within 72 hours after death with the Maryland ene. than "naturel", or Itema 23e or 28e-f show Item Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubi		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
2 5 2	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation de completed) College (1-4or 5+) 3	(Give	dent's Usual Occup kind of work done DO NOT use retired SECTE	during most of wor d) tary	king	music	
2 should be and Mental Is marked of aumatic even	To Be (17. Father's Name (First, Middle, Last) Jack Louis Putte 19a. Informant's Name/Relationship (7	ype, Print)		_	Rose S	he (First, Middle, Ma hepeloff ral Route Number, C	City or Town, State,	
es 1 an of Heal fitem ?		Donald Putterman/1 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ '4 ☒ Donation 5 □ Other (Specify	Removal from State	b. Place of Dispo			enectady,	NY 12304 c. Location - City or	
permit. Pag Department Important: I eny Injury o		21. Signature of Poparal Service icen Rona Bona 26a. Part1. Enter the disease, or compshock or heart failure. List only	lade Birect	Ba	ltimore,	MD 2120			Street Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Preces	st Can	Cer				Onset and Death
te be executed ysician and te burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cond						
the death certifica y the attending ph ched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
w requires that been signed by should be deta	þ	Part II. Other significent conditions of			nderlying cause giv	en in Part I.			o the cause of death?
	e Completed	25. Was case referred to medical	,			26 Place of Dea	24a. Was an autopsy performe 1 Yes 2 th (Check only one)	prior to	utopsy findings available completion of cause of 2 2 No
ng Phys fter this ineral dia	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		28c. Injur Wor M 1	er: 4 Nursing H	ome 5 Residence 28d. Describe how	injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		4 Homicide determined 29a. Certifier Certifying Phy	28e. Place of Injury - building, etc. (Sp. sician: To the best of my iner: On the basis of exar	vecify) knowledge, deatl	occurred at the tir	ne, date and place	28f. Location (Stree City or Town, S	State) se(s) and manner a	s stated.
To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	- 200	29c. Licens		29d	Date signed (Mont	h, Day, Year)
St	ate	30. Name and address of person who of 5601 Lock have on 31. Date filed (Month, Day, Year)	Blvd. B	seltime	Print)	21239			

			1- For State of Maryland / Department	artment of Health and M rtificate of Death	ental Hygie Reg.	611115	20110
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	/Medic	al	Anne M. Stouffer	4. C. Torrellos (Dath	JUNE 14,	2005 Year	12:25p M
	Examin	er	4a. Facility Name (If not institution, give street and number) Vantage House	4b. City, Town, or Location of Death Columbia		4c. County of Death	vard
	Funeral		Social Security Number	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birti	nplace (State or Foreign
J.	Director		210-05-2597 1□ M 2X1F 91 Yrs.	Months Days Hours Min.	NOV 28, 1	1913 Pen	nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary Ined s	tor	Maryland Howard	Columbia			1 ☐ Yes 2 🛣 No
	or 28s	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	s 23a	by Funeral Director	5400 Vantage Point Road	21044		USA	
	items items	-une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ant, the Medical Evairiline frings be rediffed at		If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify:	Mhite
2-0	72 ho	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	ng 16b	. Kind of Business/	ndustry
121	within ane. than "	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Homemaker		Own Home	
d 2	filed Hygie other ent, t		17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
/lan	should be and Mental I see marked o	To Be	Basil Musolin	Luba	Kosanovio	ch	
Maryland	CI (0 - 6			ng Address (Street and Number or Rura			
	1 and 2 Health tem 27			Vantage Point Road		2 Columbia Location - City or	
nor	ages int of I t: If ite y or o			position (Name of matory or other place) ematory, Inc. 6/15/		altimore,	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21 Signature of Euparal Service Licensee	2 Name and Address of Facility			1110
ä	Depar Impor any ir		Edward A. Gregorchik	remation Society o 99 Frederick Road	i MD, Inc Baltimore	MD 2122	28
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ct Demen	tis		
	Examiner		Due to (or as a consequence of):	10			
L	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	utis			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical E	i de ce de consequence on.	Sive Toint	Disca	00	
9	tificate g phys as the	ledic	a significant	HOC JEIGH	1300	>C	
Box	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	DEctopic pregnancy		23d. Date of deli	
O.	ne dea the at thed fo	Physiclan/Me	in the past 18 months? 1 Yes 2	Other (specify)		Month	Day Year
<u>α</u>	The taw requires that the de ate has been signed by the a page 2 should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
of Vital Records,	w requires been sign should be	ed by			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Donknown
eco	ne faw requ i has been ge 2 shouli	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u>ح</u>		Соп			performed	? death? No 1 ☐ Yes	2 No
Ĭ.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatien	26. Place of Death			~ .
	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time o	nt 3 DOA 4 Nursing Hor	me 5 🗌 Residence 28d. Describe how in		iry)
ion	utending death. ctor: Aft y the fun	atlo	2 Accident investigation	M 1 Yes 2 No			
Division	l or Atter de Director in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St		ral Route Number,
	spital lours a neral I		29a. Certifier 12 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, a	and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
,	0		30, Name and address of person who completed cause of dealn (Item 23a) (Type,	D17421		0/15/0	1
	H		1) III P B MVEAIRA AAIN 4	13 Congrande	HC AV	cateual	1/c all)
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				7-1)
	Registr	ar	JUN 1 6 2005 May 15 A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 49 **Physician** Tune a M Elnora Stanlev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSRIFAL altimore akyland General N/A 5. Social Security Number 8. Date of Birth (Month, Day, May 23, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{Year)} 1949 Days Hours 1 □ M 💥 F 56 May Director 217-54-2811 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1701 Eutaw Place Apt. 224 21217 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aid 4 Nutrition 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Samuel Stanley 2 Frances Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is y or other tra Jacqueline Stanley, Sibling 1701 Eutaw Place Apt. 706 Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Metro Crematory Inc. 06/15/05 Baltimore, Maryland 21. Signature of Funeral Service Ligensee
Thomas Gregor permit. Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Munca /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? uper tensi 2□ No 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medi examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 일 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NWA CHUKWU, MI

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type

enna

31. Date filed (Month, Day, Year)

JUN 1 6 2005

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32. Registrar's Signature

lΙ			State of Maryland / De 1- State Amend item #14&21 per fh g8444	epartment of Health and Sertificate of Death	d Mental Hygie Reg.	ne2005 20112			
	Physici	on	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death			
	/Medi		Justin Jacob Sheftel		June 15,	2005 12:38 A M			
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County of Death				
	Funeral		7701 Philadelphia Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Ocean City (ay) If Under 1 Year If Under 24 F		Worcester 9. Birthplace (State or Foreign			
п	Director		011–70–5309 ¹ X ^{M 2□ F} 18 Yr	Months Davs Hours M	Sept. 6,19	86 Massachussetts			
	pu kug		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	r Location		10d Incide Cit. Limite			
	Aaryla F sho	ō		entown		10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	the 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?			
	h with		3632 Oakwood Trail	18103		nited Chabon			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene, itam 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, The Madical Experiment must be nutilised at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 A No Specify:	(Specify Yes or No-	nited States 14. Race - American Indian, Black, White, etc. WHITE Specify: Whitee			
5-0	72 ho	ted	15. Decedent's Education 16a. D (Specify only highest grade completed) ((ecedent's Usual Occupation Give kind of work done during most of	16b	. Kind of Business/Industry			
21	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)		. 0			
	filed w Hygier ther th		17. Father's Name (First, Middle, Last)	Student		ot Self Supporting			
anc	d be fantal h	Be c	Elliott Sheftel	143	Name (First, Middle, Maid	en Sumame)			
Maryland	2 should the and Ment Is marked	T _O		lailing Address (Street and Number or	Davila Rural Route Number, Cit	y or Town, State, Zip Code)			
	and 2 ealth a m 27 is har trat			2 Oakwood Trail,					
J.e.	as 1 a of Hea litam rothe	1	20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State			
<u><u>Ĕ</u></u>	nit. Pages lartment of h ortant: If its injury or of	13	'4 □ Donation 5 □ Other (Specify)	emoria Park June	2005 White	eha11,Pennsylvania			
Baltimore,	permit. Pag Department Important: I any injury o		ral Service, P.A. rnie, MD 21061						
п			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as card	liac or respiratory arrest,	Approximate Interval Between			
	Fnysician	1	Immediate Cause (Final disease or condition resulting in death)	NJUVIES		Onset and Death			
	/Medical Examiner		Due to (or as a const uence of)						
		-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)						
/	d d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or Injury that initiated events						
ó	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of)						
8760,	cate be executed physician and the burial-transit	dlcal	d						
9		0	IF FEMALE:						
Вох	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year			
o.	t the de by the a	ıysic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (specify)					
0	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use as	by Pt	Parl II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?			
Records,	w requir been si should I				1 Yes	2 No 3 Probably 4 Unknown			
ec	e law has b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
al F					performed 1X Yes 2				
Vital	Physician: The this certificate all director, page	Be	25. Was case referred to medical examiner? Hospital:	Othor	eath (Check only one)				
of		To To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	Home 5 Residence 28d. Describe how in				
ion	nding I tth. :: After e funer	atlor	1 Natural 5 Pending (Month, Day Year) Inju	y Work? 1 □ Yes 2 No	PIEDVESTIAN	STRUCK BY AUTO			
Division	I or Attanding after death. Diractor: After	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f Location (Street	and Number or Rural Pouts Number			
	ital or A rs after ral Dirac led in by	Cer	STA	et	OCEAN CIM	ate) 710 1 Philamelphia AVP.			
	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, conduction on the basis of examination and/conduction on the basis of examination of the basis of examination and conduction of the basis of examination of examination of the basis of examination of examination of the basis of examination of	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ace, and due to the cause courred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)			
	To the within 2 To tha Complet	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)			
	. > - 0		1 MM TL I	OCME	T1 11	ne 16, 2005			
	1		30. Name and address of person into completed cause of death (Item 23a) (Ty	pe, Print) 11 Donn Street		e, Maryland 21201			
	4		2. 2. m.D.	TIT Leill Stree	TOTTINI	e, rarytanu 21201			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 6 2005 32. Registrar's Signature	D. 0					
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Registrar

		4	For State Registrer	State of	Maryland / Dep <i>Ce</i>	artment o		- 0	iene	20111.
	Physici	an	Decedent's Name (First, Middle, Howard B. Smit				<u> </u>	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, 6341 Hanover Cr	give street and numb		4b. City, Tow Hanov	n, or Location of Deat	06 - 14-2	4c. County of Deatl	1:30 p ^M
	Funeral Director		214-40-9133	6. Sex 7. 1⊠ M 2□ F	. Age (In yrs. last birthda) 64 Yrs.	/) If Under 1 Ye Months Da			Year) 9. Birth Co 41 Mar	nplace (State or Foreign unity) yland
	e Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Balti	more	10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the se or 21	Dire	10e. Street and Number 907 Grove Hill	P.A		10f. Zip Cod			og. Cilizen of What Co nited Stat	-
9003	ours after death rel', or Items 23	d by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Force	No		of Hispanic Origin? (S Cuban, Mexican, Puer		14. Race - Amer Black, White Specify:	ican Indian,
21215-0036	d within 72 h giene. rr then "netu	Completed by	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12		(Giv	edent's Usual Oc e kind of work do DO NOT use re ftsman	ccupation one during most of wo tired)	rking	6b. Kind of Business/I	ndustry ense
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28a-f show any injury or other treumetic event. It a Marical Exacultier must be multied at once.	Be	17. Father's Name (First, Middle, L Howard Garfield					me (First, Middle, M		
Maryland		²	19a. Informant's Name/Relationsh		19b. Mai	ling Address (Str			erine Brad	
			Nancy L. Smith	/ wife					ver, MD 21	076
ore			20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation		ate	ematory or other	place)		20c. Location - City or	
Baltimore,			1 4 □ Donation 5 □ Other (Sp. 21. Signa ur of Funeral Service L	icemee UUUl		22. Name and Ad 328 Sul	oddress of Facility Am phur Sprin	brose Fun g Rd Arbu	altimore, eral Home, tus, Maryl	Inc
	Physician /Medical Examiner		23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. 4	r as a consequence of):		dying, such as cardia	c or respiratory arre		Approximate Interval Between Onset and Death
8760,	ite be executed iysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):					2770707,13
O. Box 6	that the death certifica ed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	nt at time of death 5	□Ect <i>o</i> pic pregna □ Other <i>(specif</i> y			23d. Date of deli- Month	very Day Year
rds, P.	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant condition ALCOHOL		th but not resulting in the	underlying cause	given in Part I.	23e. Did tob	acco use contribute to	
Vital Records,		Completed by						24a. Was an autopsy perform 1 ☐ Yes 2	prior to c ed? death?	opsy findings available ompletion of cause of 2 □ No
Division of Vita	ding Ph h. After th funeral	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig: 3 Suicide 6 Could n determine	ot be 28e. Place o		of 28c. I	Other: 4 Nursing F njury at Work? 1 Yes 2 No	ath /Check only one lome 5 Resider 28d. Describe how 28f. Location (Str. City or Town,	nce 6 her (Spec w injuly occurred	// - - - - - - - - - -
ā	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier	Physicien: To the b	est of my knowledge, dea	th occurred at th	e time, date and place	, and due to the ca	use(s) and manner as	stated.
	To the Ho within 24 h To the Fu completely	Medical	one)	xaminer: On the bas and manne	is of examination and/or ir stated.					
	wit To	-	29b. Signature and title of outsider	1			ense number 050229	29	d. Date signed (Month	/ -
	10		JEFFREY LOS	who completed cause	NOD 46	Print) Wi	150229	AVE.	BARTIM	ore my
	Sta Registr		31. Date filed (Month Day, Year)	6 2005 32. Re	pistrar's Signature	locales.				

	∍TT	ers _{or} State of Maryland				ınd Mental H	lygiene	005	75 75 1 1 1
		Registrar	Cert	tificate of	Death		Reg. No	UUJ	4011
		Decedent's Name (First, Middle, Last)				2. Date of Month			3. Time of Death
Physic		Magdelena R. Soellers				June	Day 1 ᠘	Year 2005	8:30 A
/Medi Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location o			OUD_ ounty of Deat	
Exami	ier					Death	40. 0		1
		1132 Roland Heights Avenue		Baltimo		2411-		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Yea Months Day		Min. (Month.	Birth Day, Year)	9. Birt	nplace (State or Foreig
Director		210-10-1203 - 83	Yrs.			Sept.	1, 19	34 36	ryĺand
ō	1	Usual Residence of Decedent							
ylar			Town or Loca						10d. Inside City Limits
Mai	ğ	Maryland N/A Ba	altimo	re					XXYes 2 □ No
the 28a	e G	10e. Street and Number		10f. Zip Code			10a Citiza	n of What Co	untar?
72 hours after death with the Maryland natural, or items 23s or 28s-f show disal Examinat must be notified at	Funeral Director	1132 Roland Heights Avenue		101. Zip 0000	2121	1	Tog. Citize		unity:
ath 7	- Ca	1132 ROTAIN HEIGHTS AVEING			2121	1		USA	
ep Swa	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of	Hispanic Orig	in? (Specify Yes or , Puerto Rican, etc.)	No- 14	. Race - Ame	
after or it	교	1X⊒Never Married 2 ☐ Married 1 ☐ Yes 2√√No				, i dono rnodn, etc.)		Black, White	
IIS	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	11	☐ Yes 2 (21)No	Specify:		S	pecify:	White
hor hou	pa	15. Decedent's Education	16a Decede	ent's Usual Occi	ination		16h Kina	of Business/I	ndustra
27 r	Completed	(Specify only highest grade completed)	(Give k	and of work done	e durina most	of working	TOD. KITC	or business/i	ridustry
within 7 ene, than "r	ద	Elementary/Secondary (0-12) College (1-4or 5+)		O NOT use retir	ea)			_	
filed withi Hygiene, other than	Ö	8	Ho	memaker				Own F	lome
e H H	Be (17. Father's Name (First, Middle, Last)			18. Mother	r's Name (First, Midd	lle, Maiden S	ımame)	
ould be f Mental I warked of	To E	Henry Soellers			Jul:	ia			
should Ind Men	-	19a. Informant's Name/Relationship (Type, Print)	10h Mailing	Address (Street	t and Numbo	r or Pural Cauta Nue	ahan Cibara i	Ct-4- 7	7- C- d-1
2 sho and is m						r or Rural Route Nun			
and salth n 27		Michael Dodge			ht Cou	rt Baltimo	ore, Ma	iryland	21225
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Madical Examinat must be notified at edge.	1 1		ce of Disposi	ition (Name of atory or other pl	ace)	Date	20c. Loca	tion - City or	Town, State
age onto		1 🖾 Burial 2 □ Cremation 3 □ Removal from State Holy	v Rede	ermer C	em.	6/17/2005	Balti	more.	Maryland
permit. Pa Departmer Important any injury once.		· Essilari o Borner (opcony)	- 1					,	-141 / 14114
permi Depa Impo any ir		21. Signiture of Funeral Service Licenses	R ₁₁	Name and Add	ness of Facility	/ itz Eupore	1 Home	Tno	21211
40 E # 9		Vum 19. Huss	36	31 Fall	s Road	itz Funera , Baltimor	e. Mar	vland.	21211
		23a. Part1. Enter the disease, or complications that caused the death.	Do not enter	r the mode of dy	ing, such as o	cardiac or respiratory	arrest,	James	Approximate
ALE		shock, or heart failure. List only one cause on each line.							Interval Between Onset and Death
Priysician		disease or condition 4+ Lawsclar	retic	Caralle	Vasu	stor di	rase	,	
/Medical		resulting in death) Due to (or as a consequent							
Examiner									
	io i	Sequentially list conditions, b. Due to (or as a consequer	inne offi					-	
bed is	Ē	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
be executed sician and burial-transit	Examiner	that initiated events							
an a		Due to (or as a consequent	ince of):						
e be sici	cai	d.							
leath certificate attending phys I for use as the	Physician/Medic								
ding ding	₩.	IF FEMALE:							
tence tence	an	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de		Ectopic pregnan	cv		23	d. Date of deliv	,
dea e at od fo	io	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of deat	th 5 🗆 (Other (specify)	,			Month	Day Year
the y th iche	ys	9 ☐ Unknown							
The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but not resulting	ing in the unc	derlying cause o	Iven in Part I	23e. Die	d tobacco use	contribute to	the cause of death?
res	by	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	g	,	and the same of				
w requir been si should I	ed						」Yes 2∐I	No 3∏Pro	bably 4 Unknown
w re be	Completed					24a. W	is an	24b Were aut	opsy findings available
The lay	붑					—— aut	topsy formed?	prior to or death?	ompletion of cause of
H egg	Ö					1 ☐ Yes			2□ No
		25. Was case referred to medical			26. Place	of Death Check onl	one		
	0	examiner?						Other (C-	(fee)
	Be	Hospital:	2/Outpotions	2004 0	ther: 4 Thurs		sidence 6	Jotner (Speci	(Ty)
Physician: this certifica al director, p	To Be	Mary es 2 No Hospital: 1 □ Inpatient 2 □ ER		3 DOM		sing Home 5X Re		a accorded	
Physician: rthis certifica ral director, p	To Be	Hospital: 1 ☐ Inpatient 2 ☐ ER 27. Manner of Death 28a. Date of Injury, 28	R/Outpatient 8b. Time of Injury	28c. Inju	ury at ork?	28d. Describe		ccurred	
Physician: rthis certifica ral director, p	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)	8b. Time of	28c. Inju	4 🗀 IVUI:	28d. Describe		ccurred	
tanding Physician: leath. tor; After this certifica the funeral director, p	To Be	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	8b. Time of Injury	28c. Inju	ury at ork? □ Yes 2 □ N	28d. Describe	e how injury o		al Route Number,
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To the Hospitel or Attending after death. 24 hours a within 2 To the

6X Could not be determined Scene

29c. License number

111 Penn Street

OCME

28f. Location (Street and Number or Rural Route Number, City or Town, State) 23670 Cedar Lane Rd Leonardtown, Md Leonardtown,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

June 9, 2005

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) min 1 LING 7

JUN 1

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6 2005

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32. Pristrar's Signature

Amend itestate Bernary and Department of Health and Mental Hygiene State
Registraramend item #12 per 2 per fh g8/24 tificate of Beath Joseph D. Smothers Sr. Reg. No.... 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yea **Physician** JMOTHERS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. Medica enter tillicn 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Hours Min 1**X** M 2 ☐ F 214-14-6470 02 MD 04 Director 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County r iteme 23a or 28e-f ehow trer must be notified at XIXIYes 2 □ No Baltimore NA Direct 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21202 U.S.A. Street Apt 210 West Conway death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married Married filed within 72 hours after ò 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "nature!" Completed the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Dept. of Elementary/Secondary (0-12) College (1-4or 5+) : If Item 27 is marked other than or other traumatic event. It is a Agricultural Animal Care Taker 12th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Sarah Mathews Smothers Frederick S. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) 1 West Conway Street Apt 210, Baltimore, Md Una Smothers-Wife 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny inlury or once. Maryland National 6/16/05 Laurel, Md 21. Signatur of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Myocardia Miny disease or condition to be sulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the burial by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 2 ER/Outpatient 1 Inpatient 3 DOA ٩ 1 Yes this 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and utle of certifier address of person who completed cause of death (Item 23a) (Type, Print) Mediza Merry USMO 32. Pegistran's Signature Date filed (Month, Day, Year)
JUN 1 6 2005 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Bey 1/2001

Registrar

ORIGINAL

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Certificate of Death Reg. No. 2005 2018
	Physic /Medi Exami Funeral	cal	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day, Year 3. Time of Death Month Day, Year 3. Time of Death Day, One of Death Day, One of Death Day, Year 3. Time of Death Day, Year 3. Time of Death Day, One of Death Day, One of Death Day, Year 3. Time of Death Day, One of Death Day, Year 3. Time of Death Day, One of Death Day, One of Death Day, One of Death Day, Year 3. Time of Death Day, Year 3.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumatic event. Its Medical Evaring met he notified at 200ce.	To Be Completed by Funeral Director	216-16-8596 2
68760,*	cate be executed // Medical bluysician and physician and physician and street fitters it is the burial-transit	ledical Examiner	March F/H West 4300 Wabash Ave, Baltimore, Md 21215 28a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Inmediate Cause (Final disease) or condition resulting in death) Sequentially list conditions, If any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Due to (or as a consequence of): Caram Neathor Septimental Septiment Sepiment Septiment Septiment Septiment Septiment Septiment Septimen
Box 6	The law requires that the ate has been signed by th page 2 should be detache	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Day Year 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) Month Day Year 23d. Date of delivery Month Day Year 24d. Was an autopsy Performed 24d. Was an autopsy
Division of Vita	ing Physicien: Mer this certific uneral director,	Certification; To Be C	25. Was case referred to medical examiner? 1
]	To the Hospitel or Attendivity and the form within 24 hours after death To the Funerel Director:	Medical Ce	29a. Certifler (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)
	Sta Registr	4.7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Mire DNA him? M. J. 10 Mary and Creneval Auspital 31. Date filed (Month yan Yan) 6 2005 32 Registrar's Signants

			1- State Unpend Item	State of Ma 23a, pt.II,	aryland / Dep 27 per me <i>Ce</i>	artment G845 rtificate	of H	ealth a Death	and Nas	lental H	lygier Reg. 1	ne 1020	05	20119
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	Funeral Director		5. Social Security Number 6. S 217-06-5882	M 2□F	e (In yrs. last birthday) 20 Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of (Month,	Birth Day, Yea 11	0 /	Cour	
			Usual Residence of Decedent		20					00	TT	04		MD
	nylani how		10a. State 10b. County		10c. City, Town or Lo	ocation							1	0d. Inside City Limits
	e Ma	cto	MD NA		Baltimo	re								YYYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip (Code				10g. (Citizen of V	Vhat Cour	ntry?
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Baltimore,	ages or or o		MBurial 2 ☐ Cremation 3 ☐		cemetery, crei	natory or oth	er place				200.	Location -	City or To	wn, State
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7	(2)		1 allien (Monica	- Jalak		CME				June	e 13,	2005	5
	10/		30 Name and address of person who	completed cause of de	ath (Item 23a) (Type,		1 Pa	enn S	tree	t Ra	l t i ma	ore 1	Marv1	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	2. Registra	r's Signature	<u> </u>			OF C.C.	.c Da.		, ,	тит у 1	21201
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			1 - For State Registrar			ertificate of			3. No.	20120
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	/Medio		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death	June	4c. County of Deatl)
			North west 5. Social Security Number 6	Hospita.	Age (In yrs. last birthda	Randa v) If Under 1 Year	NStoDD	0 Date of Birth	Baltimo	
	Funeral Director		214–58–8393	1 M 2 M F	83 Yrs.	Months Days	Hours Min.	8. Date of Birth 03/28/19	22 M	pplace (State or Foreign untry)
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	with th	Dire	10e. Street and Number 7920 SCOTTS LEV	FL ROAD		10f. Zip Code 21208		109	g. Citizen of What Co USA	untry?
	ems 2	inera	11. Marital Status	12. Was Decede	ent Ever in U.S. 13	3. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp an. Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
936	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show to Modical Examination mail be multified a	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	M TNo	1 □ Yes 2X□ No		,	Specify: WH	
21215-0036	72 ho "natura	eted	15. Decedent's (Specify only highest		(Giv	edent's Usual Occup ve kind of work done	during most of work	ing 16	6b. Kind of Business/I	ndustry
2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or items 23a or 28a-f show any injury or other traumatic svant, the Moded Examination at the notified at once.	ошо	Elementary/Secondary (0-12)	College (1-4	or 5+)	NONE NOT use retire	a)		NONE	
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Maryland		To	MEYER 19a. Informant's Name/Relationship	(Type, Print)	SCHW.		GOLDIE	al Route Number, (City or Town, State, Z	COHEN ip Code)
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Baltimore,	ages 1 ant of H it: If ite y or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ate 1	ematory or other pla	сө)		Oc. Location - City or	
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9	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit		IF FEMALE:							
Вох	death or attend	clan/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No		h 2 Fetal death 3	B □Ectopic pregnanc	у		23d. Date of deli Month	/ery Day Year
P.O.	at the d	Phys	9 🗆 Unknown	9□ Unknow						
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n 0	ing Phys	lon; T	27. Manner of Death 1 Natural 5 □ Pending		Injury 28b. Time Day Year) Injury	Wo	ry at rk?	28d. Describe how		
Division of	Attending ir death. ector: After by the funer	Certification;	2 Accident investiga 3 Suicide 6 Could no	t be 28e. Place of	f Injury - At home, farm,		Yes 2□No		et and Number or Ru	ral Route Number,
Ö	urs afte ral Dire	Cert	4 Horricide	building	, etc. (Specify)			City or Town,	<u> </u>	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying 2 Medical Example	Physicien: To the basi eminer: On the basi and manner	est of my knowledge, de: is of examination and/or r stated.	ath occurred at the ti- investigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens		290	d. Date signed (Month	, Day, Year)
	A		30. Name and address of person w	no completed sauce	of death (from 23a) (Time		35844)	une II,	2017
_	7		D Roggen		or death (tieth 23a) (1yp	5	401 Old	Court R	oad Rand	allstian, mI
	Sta Registi		31. Date filed (Month, pany eq)	2005 32.	istrar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11 per fh 844 6-16-05 vt. State of Maryland / Bepartment of Health and Mental Hygiene 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3 Time of Death **Physician** Month 4c. County of Death 650 AM 1ae lones UNE /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death TORIAC 4105 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Y 6. Sex 9. Birthplace (State or Foreign **Funeral** 248-68-006 Year) Min 1 M 2 F 73 Months Days Hours Director South Usual Residence of Decedent 10b. County City, Town or Location 23a or 28a-f show 10d. Inside City Limits The Mudical Examiner must be notified at 1 Yes 2 □ No Director +IMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1200 M AUE Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Itams 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. int: If item 27 Is marked othar than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 TZ Yes 2 No Specify. TICAN AMERICAN þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ine COORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY Anderson ပ 1/18 19a. Informa 's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roule Number, City or Town, State, Zip Code) 212/6 permit. Pages 1 and 2 Department of Health a Important: If item 27 la any injury or othar trat once. 2505 Altimore MARYHAR IME LEROY AUE Kosalind 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State lune 19 Prinity Centery 4 □ Donation 5 □ Other (Specify) 21. Signat e of Funeral Service Licensee ANCY 11. WACCACE Service FURRAM 3405 JW. FRANKIN Street-Baltimore MARYLAND 21259 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LOUV /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and tor use as the burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached the 9 Unknown þ signed d be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown need 24b. Were autopsy findings available prior to completion if cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 _ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 No 1 Tyes 2 ER/Outpatient 50A this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After 1 Natural 5 Pending death. investigation 1 Yes 2 No Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after filled within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

1

31. Date filed (Month, Day, Year, State Registrar

29b. Signature and title of certifier

30. Name and address of person

32. Registrar's Signature

29c. License number

			1 - State Registrar	ryland / Departme <i>Certifica</i>	nt of Health and M te of Death	ental Hygien	2005 20122			
	Physici /Medi Examir	cal	4a. Facility Name (If not institution, give street and number)	1 - 1	y, Town, or Location of Death	June 1	3. Time of Death 2 200 5 6 0 0 M c. County of Death			
	Funeral Director		104 20		er 1 Year If Under 24 Hrs. Bays Hours Min.	8. Date of Birth (Month, Day, Year 08 • 12 • 1924	9. Birthplace (State or Foreign OH			
	the Maryland 28e-f show	rector	10a. State 10b. County NA	10c. City, Town or Location CLEVELANO 10f. Z	ip Code	10a.C	10d. Inside City Limits 1 ☑Yes 2 ☐ No itizen of What Country?			
36	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show alreal Examin net most be predified at	by Funeral Director	3738 EAST 151 STREE 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 M Widowed 4 Divorced 1 STREE Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	ver in U.S. 13. Was Dec	44120 edent of Hispanic Origin? (Spe ecrty Cuban, Mexican, Puerto I		USA 14. Race - American Indian, Black, White, etc. Specify: BLACK			
Maryland 21215-0036	within ene. than *	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-1) A A A	16a. Decedent's Us (Give kind of w life. DO NOT CATERE	rork done during most of workir use retired)	ng	Kind of Business/Industry DD SERVICE			
ıryland	d 2 should be filed th and Mental Hygi ? I e markad other traumatic event, I	To Be	17. Father's Name (First, Middle, Last) 10 MMIE CROCKET 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres	18. Mother's Name EDNA HA as (Street and Number or Rura.					
	les 1 and of Health If item 27 or other to		HAYWOOD TRUIT (SON) 20a. Method of Disposition		DEN ROD PATH	COLLIMBI				
Baltimore,	permit. Pag Department Important: I any injury c once.	1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility AUGHN C. CREENE FUNERAL SERVICE 5151 BAYO. NATU PIKE, BAYO. MD 2122								
	Medical Examiner physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	he death. Do not enter the mo		respiratory arrest,	Approximate Interval Batween Onset and Death			
O. Box 68760,	that the death certificate be ed by the attending physicit detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetal death 3 Ectopic p			23d. Date of delivery Month Day Year			
ords, P.	requires een sign nould be	þ	Part II. Dther significant conditions contributing to death but	not resulting in the underlying	cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?			
Vital Record	The la ate has page 2	Be Completed	25. Was case referred to medical examiner?		26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 No.	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 10			
of	S S	၉	27. Manner of Death Natural 5 Pending 2 Accident Accident Hospital: 1 Inpatien 28a. Date of Injury (Month, Day)			e 5 ☐ Residence 8d. Describe how inju				
Divis	D Yit fe	ai Certification:	3 Suicide 4 Homicide 4 Certifier 29a. Certifier 1 Certifying Physician: To the best of			City or Town, State				
ı	To the Hospital within 24 hours a within 24 hours a To the Funerel C completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of e and manner state 29b. Signature and title of certifier	examination and/or investigation	n, in my opinion, death occurre	d at the time, date and	d place, and due to the cause(s)			
_	12		30. Name and address of person who completed cause of deal Ramesh Sabapath	ith (Item 23a) (Type, Print)	Back River 1	veck Road	te signed (Month, Day, Year) ne 14 2005 d Baltimory Mayland 21221			
	Sta Registr	700	31. Date filed (Month, Day, Year) 32. Registra	Signature	outs?		Q TAX			

Antuan Thornton 05-03968 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Unpend Item 238,27,28a-1	Ce	runcate or i	Deain					23
Physici	an	Decedent's Name (First, Middle, Last) ANTUAN THORNTON				2. Date of Death Month	Day 09	Year	3. Time of	
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4h City Town or	r Location of Death	June		2005 ty of Death	5:01	P ^M _
Examili	ier	Northwest Hospital Center			allstown		10. 004.	Balti	more	
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Voarl		ace (State o	or Foreign
Director		217-71-0846	Yrs.	Months Days 5 3	Hours Min.	1-6-20	05	MARY	LAND	
land bw			c. City, Town or Lo	ocation	-			10	Od. Inside Ci	ity Limits
within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show he Madical Examinar must be notified at	tor	MD. N/A	BALTI	10RE					1XX es	2 🗌 No
th the or 28	by Funeral Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of	f What Coun	try?	
23a	ral	2021 CECIL AVE.		212	18		USA	<u> </u>		
or dek	nue	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - America ack, White, e		
rs afte	y F	1 ☒ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2. XXVo	Specify:		Spec	ity: BL	ACK	
2 hou	pa	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	1 1:	6b. Kind of I	Business/Inc	lustry	
hin 77	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worki	ng			,	
giene giene er tha	Com	-00-								
be file tat Hy d oth event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Suma	ıme)		
Men Marke Patic	2	STEVEN D. THORNTON, SR.				JOHNSON				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heathl and Mental Hygiens. Important: It item 23a or 28e-1 show important: Item 27 is marked other than "natural", or items 23a or 28e-1 show eny injury or other traumatic event, the Marical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, Print) LINDA THORNTON (MOTHER)		-	a <i>nd Number or Rur</i> a E. BALTIM(Code)	
s 1 an f Heal item 2 other			Ob. Place of Dispo	sition (Name of				- City or To	wn, State	
Page: ent o nt: If		1 ☐ Burial 2 ★ Cremultion 3 ☐ Removal from State 1 ☐ Donation /5 ☐ Other (Specify)	METRO CE	natory`or other plac EMATORY		-2005 BA	ALTIMO	DRE. M	ARYLAN	ND.
mit. partm porta porta r inju		21. Signature of run rai Service Licencee JONATHAN I			ss of Facility PHI	LLIPS FUI	NERAL	HOME,	P.A.	
Depa Impo eny ir		Joseth V. PhBro	\mathcal{L} 17	21-27 N.	MONROE S'	r. BALTI	MORE,	MARYL.	AND 21	217
Physician /Medical Examiner ponujal-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sudden Un Due to (or as a co	nsequence of):	d Death i	n Infancy	(SUDI)			Interval Betwonset and D	
the death certificate by the attending phy ached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of the past 12 months? 4 ☐ Pregnant at time of the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	-	⁄ear
uires tha signed I d be det	by	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	~		a cause of de ably 4 □U	
w requir been si should	iete					24a. Was an	24h	Were autop	sev findings	available
cate has	Completed					autopsy		prior to com death?	pletion of ca	luse of
yelcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Cth	26. Place of Death				- 555	
rnyer this or	L.	X 193 2 10 1 Inpatient	28h Time of		4 Nuising Hor	ne 5 🗌 Residen 28d. Describe how		and d		
death. ctor: After	Certification:	1 □Natural 5 □ Pending (Month, Day Yei investigation 6-9-05	28b. Time of Found 4:13	PM 28c. Injury Work	Yes 2X No			un		
or Att	ı <u>İ</u>	4 Homicide determined 288. Place of injury building, etc. (S	pecify)	eet, factory, office	2	28f. Location (Stre City or Town,	et and Num State) 83	24 Sco	Route Numb	evel
Funeral E		private dw 29a. Certifier 1 Certifying Physician: To the best of my				d. Balti				/land
within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifler (Check only one) 29a. Certifler (Check only one) 1□ Certifying Physician: To the best of my one one one one one one one one one one	mination and/or in	vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau ad at the time, date	se(s) and m a and place,	anner as sta , and due to	ited. the cause(s))
within 2 To the complet	Me	29b. Signature and tive of centifier \		29c. License		290	d. Date signe	ed (Month, E	Day, Year)	
> - 0		MANN		OC	ME		June 1	0, 20	05	
	()	30. Name and address of person who complet id cause of death	(Item 23a) (Type,		C+ ·					1
		5.16.40GAN		III Penn	Street	Ralt1mor	e, Ma	ryland	1 2120.	T
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's S JUN 1 6 2005	oignature							

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			State of Maryland / Depa	artment of Health and Martificate of Death		2005	20124				
	Physic	ian	1. Decedent's Name (First, Middle, Last)	1	2. Date of Death Month	Day Year	3. Time of Death				
	/Medi	cal	Barry Ross Thompson		9	14 2005	10:35 AM				
1	Examir	ner	4a. Facility Name (If not institution, give street and number) Baltimore VA Medical Center	4b. City, Town, or Location of Death		4c. County of Death					
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthp	ace (State or Foreign				
	Director		216-06-5858 XIM 2 IF 35 Yrs.		(Month, Day, Ye		MD				
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		14	Od. Inside City Limits				
	Maryl f sho	ŏ	MD NA Baltimo	re		1,"	1 ☑ Yes 2 ☐ No				
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?				
	23a c	al D	3406 Merle Drive	21244		U.S.A.					
	er dea terne	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. I Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - America Black, White, e					
36	irs aft	by F	1 X Never Married 2 Married 1 X Yes 2 No	□ Yes 🛣 No Specify:		Spanifu	Black				
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or iteme 23a or 28e-f show event. The Marical Examiner must be notified at	ted	15. Decedent's Education 16a, Decedent	lent's Usual Occupation	166	. Kind of Business/Ind					
218	ithin 7	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working OO NOT use retired)	g		,				
121	filed within Hygiene. Ither than "			sabled		Disable	∍d				
anc	d be find He ed of	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		den Sumame)					
Z Z	should be and Mental is marked o	T _o	Calvin Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Janice		tv or Town State Zin.	Codel				
Janice Greene-Mother 3406 Merle Drive, Baltimore, Md 2											
ore,	of Heal		20a. Method of Disposition 20b. Place of Disposition	sition (Name of Danatory or other place)	-	. Location - City or Tov					
Ë	Pag nent ant:		TEDONIA E COMMISSION O CHEMOVALINOM STATE	morial Park 6/1	8/05 r	andallsto	own, Md				
Baltimore,	permit. Departr Importe any inju			Name and Address of Facility arch F/H West							
	au = e a		1 Mull Hilles 4	300 Wabash Ave.	Baltim		21215 Approximate				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
	Pnysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):				0 days				
	Examiner										
i de	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Disease or inferred) that initiated events c.								
10	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C								
8760,	rate be executed hysician and the burial-transit	icai E									
9	rtificate ng phys as the		TE SERVICE								
Вох	death certifica e attending ph id for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliver					
		Physician/Med		Other (specify)		Month E	Day Year				
	res that the igned by be detaction		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?				
Vital Records,	law requires that the as been signed by th 2 should be detache	d by	pancreatitis		1 ☐ Yes		bly 4 ⊠ Unknown				
000	aw require s been si 2 should b	piete			24a. Was an	24b. Were autop:	sy findings available				
<u> </u>	The ate h	Completed			autopsy performed 1 Yes 2 X	prior to com death?	pletion of cause of				
/ita	yslcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (
of	Phys this al dii	<u>2</u>	1 ☐ Yes 235 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a, Date of Injury 28b, Time of			6 ☐Other (Specify)					
	Attending in death. sctor: After by the funer	tion	27. Manner of Death 1 Ratural 5 Pending (Month, Day Year) 2 Accident investigation	28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in	lury occurred					
Division	Atter or dea ector by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre		f. Location (Street	and Number or Rural	Route Number,				
Ö	rs efte el Dire ed in b	Cert	4 Homicide building, etc. (Specify)		City or Town, St	λ(θ)					
	To the Hospitel or Attending Is within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	ro the vithin ro the	Me	29b. Signatury and title of centifier	29c. License number	29d. [Date signed (Month, Da	ay, Year)				
	. , , ,) (MA)	P18599		ne 14, 2					
i	4.+1		30 Name and address of person who completed cause of death (Item 23a) (Type, F	rint)							
	Sta	te	HManda L. Harington M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 6 2005	10 N. Greene	JT_ 150	TIMOS I	100 MyO(
	Registr		JUN 1 6 2005 June 15 April								

amend item# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:25 PM 2005 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** of Baltimore sinae Hospit haltmore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 26, 1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 AUSTRIA 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 1 F 95 220-30-5896 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location ortent: If item 27 is marked other than "naturel", or items 23s or 28a-1 show injury or other treumatic event, it e Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE #133 21208 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: WHITE þ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: if item 27 is marked other than " Elementary/Secondary (0.12) College (1-4or 5+) **BOOKKEEPER** EDDIE JACOBS CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **BERNARD SCHIRER** DEBORAH **GOLDENBERG** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRI TAUSIK / SON 3-C REGALIA COURT OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED \06/15/2005 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Comoand 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovasculoir **Physician** t den /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Hypertusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Deatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number render 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morer O. Qi Keurissa 31. Date filed (Month, Day, Year) JUN 1 6 32 Registrar's Signature State 2005 Registrar

ORIGINAL

			1 - For State of Maryland / Departr Certifit	ment of Health and Micate of Death	Reg. I	2000	20126)				
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death					
	/Medic		Lillie Margaret Walker	Sit. Tay and position of Dooth		9 2005 4c. County of Death	3:55 PM	1				
	Examin	er	4a. Facility Name (If not institution, give street and number) Woodside Senior Care Center	city, Town, or Location of Death Silver Spring		Montgome						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If		8. Date of Birth		place (State or Foreig Intry)	חו				
	Director		579-28-7702 1 M 20 F 89 Yrs. M	onths Days Hours Min.	8. Date of Birth (Month, Day, Ye. July 17, 1	915 Nort	h Carolina	ì				
	put *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatic	on			10d. Inside City Limits					
	Aaryle f sho	ō	D.C. Washington				1⊠Yes 2□No					
	28a-	rect		10f. Zip Code	10g.	Citizen of What Cou	intry?					
	h with 23a or st be	a D	3618 New Hampshire Avenue, N.W.	20010		USA						
920	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. Is marked other then "natural", or Items 23s or 28s-f show martic event, the Midical Expliner must be nutified at	by Funeral Director	1 Never Married 2 Married 1 Yes XXNo	Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto F Yes 2 A No Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.					
2	72 ho natur	eted	(Specify only highest grade completed) (Give king	's Usual Occupation d of work done during most of working		. Kind of Business/l	ndustry					
2	vithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		Medical						
22	Hygiel Hygiel thert	ပိ	12 Nurse	18. Mother's Name	(First, Middle, Maid							
and	d be id be the bental liked o	To Be	Wade Hampton Barnette		lberta Heath Barnette							
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" or Items 23a or 28a-f show important: If item 27 is marked other then "natural" or Items 23a or 28a-f show appring representation of the Marical Examinet must be natified at once.	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or Rura								
Ž					n, DC 2001	10						
Baltimore,				n Cemetery 6/17/		ntwood, M						
Balt	permit. Departi Import eny inj		1/1/bh William 383	1 Georgia Avenue	tney's Fu , NW, Was		•					
	Physician		23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Approximate Cause (Final disease or condition a. Coronary Artery Disease Coronary List only one cause on a cardiac or respiratory arrest, Interval Onset a disease or condition a. Coronary Artery Disease									
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				·					
	LXammer	<u></u>	Sequentially list conditions, if any, leading to immediate b. Hypertensive Cardio Due to (or as a consequence of):	ovascular Diseas	e		5 years					
	insit	Examiner	Cause (Disease or injury									
oʻ	ate be executed thysician and the burial-transit	Еха	that initiated events c									
8760,	ate be physicia the but	ical	d									
ũ	entifica ing ph e as th	Med	IF FEMALE:									
O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as	Physician/Medical		topic pregnancy ther (specify)	23d. Date of delive		very Day Year					
<u>α</u>	res that the signed by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?					
rds	quires on sign				1 🗆 Yes	2. No 3 □ Pro	obably 4 Unknow	n				
Vital Records,		Completed			24a. Was an autopsy performed 1 Yes 2	prior to c death?	topsy findings available ompletion of cause of 2 No	e				
Vita	Attending Physicien: Th r death. sctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		0.000						
of	this al di	5	27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 ☐ Residence 28d. Describe how in		ity)					
O	ding th: : Afte fune	tlor	XX Natural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No								
Division	To the Hospitel or Attending Ph within Z4 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St		ral Route Number,					
	ne Hospite 24 hours 16 Funere sletely fille	edical C	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death oc 2 Medical Examiner: On the basis of examination and/or invest and manner stated.									
)		Me	29b. Signature and title of certifier 2 Oc O augh Bellor, m.D.	29c. License number MD Q 5580		Date signed (Month)	n, Day, Year)					
	1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Devoughn Belton, MD 1629 Columb	oia Road, N.W. Wa		D.C. Su	Lte 334					
	Sta		31. Date filed (Month, Day, Year) 1 6 2005 Regist (rs Signature	Greeks)								
	Regist	rar	3011 2 3 - 1	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month WILLIAMS **Physician** JUNE AMES 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner RANDALLI TOWN BALTIMILE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 4. John Day. | 1. John 7. Age (In yrs. last birthday) 95 Yrs. Number Birthplace (State or Foreign County) **Funeral** 213-09-034 Director Usual Residence of Decedent 10a. State City, Town or Location 10d. Inside City Limits or 28e-f show other treumetic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No baltimore wings 10f. Zip Code 10g. Citizen of What Country? 2111 or items 23a by Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or iten any injury or other treumetic event, the Medical Examinan ands. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Blac 4 Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use etired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary econdary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 20a. Nethed of Disposition Burial 2 Cremation 3 Removal from State ☐Donation 5 ☐ Other (Specify) gnature of Funeral Service Lid 1stown, MD 21133 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SCVD Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 Yes 2 Ho or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. I Director: After t 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospitel within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVI

JUN 1 6 2005

31. Date filed (Month, Day, Year)

JUNE

2001

			For State	State of Maryland 7			d Mental Hygi	iene	
		2.	Registrar	and)	Certificat	e of Death		g. No.	5 20128
	Physici /Medic		1. Dependent's Name (First, Middle, L	WIJTIGH	\mathcal{T}		2. Date of Deal	Tay OS	ar 7:16pM
	Examin	100	1 6 - 1):1	ive street and number	4b. City,	Town, or Location of E	eath	4c. County of E	Peath
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last 12M 2 F 56				Year) 9.	Birthplace (State or Foreign
	Director		216-52-2051 Usual Residence of Decedent	10XM 20 F 56	Yrs. Months	Days Hours I	Min. 12-18	48/	Jary/and
	yland now		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	8a-f sl	ector	MD	<i>B</i> 0	Utim	ore			1 Yes 2 □ No
	rs after death with the Marylan I, or Itams 23s or 28a-f show naminer must be notified at	Funeral Director	10e. Street and Number	in Road	10f. Zip	21214		og. Citizen of What	Country?
	r death	unera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deced	dent of Hispanic Origin city Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		merican Indian, Vhite, etc.
920	72 hours after death with the Maryland netural', or Itams 23s or 28s-f show iteal Enstringt must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: K	Black
5-0036	n 72 hours "netural" edical Ex	Completed	15. Decedent's (Specify only highest g		Sa. Decedent's Usua (Give kind of wo	rk done durina most of	working	16b. Kind of Busine	ess/Industry
2121		dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	IIIO. DO NOTU	chech	anics.	Baltima	ore City
	be filed tal Hyg d othe event,	Be C	17. Famer's Name (First, Middle, Las	st)	90000	18. Mother's	Name (First, Middle, M	faiden Sumame)	, /
Maryland	2 should be t and Mental is marked c	۵(9a. Informant's Name/Relationship	Tri akt	9b. Mailing Address	(Street and Number o	r Rural Routa Number,	City or Town Stat	ray Zin Code)
	ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If itam 27 is marked other than or other traumatic event, Itam		Claude & W	right (Well)	6217A	larim	ld, Ba	140 MC	21214
Baltimore,	iges 1 of He if itan or oth		20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3		of Disposition (Nartery, crematory or o	ne of place)	6-21-05	20c. Location - City	or Town, State
altim	permit. Pag Department Important: I any injury o		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic	Lui	150 V 70 Name ar	DEST EMED	y c	ungsi	1/15/91
ä	permit. Departr Importa any inj		Van W.	Simo	Valla	0500	erld	Sal to	ND 21212
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused the death. D ly one cause on each line.	o not enter the mod	le of dying, such as car	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	HILUK	, [119
30	Examiner		Sequentially list conditions,	b. LIVER H	ETASTI	400			971
	nted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Distriction to (or as a consequence of the conseque	in NCE	ER			14
,	be executed iician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
68760	ate hys	edical	•	d					
Box (IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	ıth 3 ⊟Ectopic pr	***************************************		23d. Date of	delivery
.O. B	0 0	Completed by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death				Month	Day Year
Δ.	requires that the een signed by th hould be detache	y Ph	-	contributing to death but not resulting	g in the underlying o	ause given in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
of Vital Records,	w requires that been signed b should be deta	ted b					1 ☐ Ye	s 2 No 3	Probably 4 Unknown
Seco.	aw ls b	nple					24a. Was an autopsy	prior	autopsy findings available to completion of cause of
tal	Th ate pa	e Co	25. Was case referred to medical			GE Place of	perform 1 Yes 2 Death (Check only one	No 1U	res 2□ No
Ϋ́	Na di S	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DC		ng Home 5 Aesider		Specify)
o u	D 0 0		27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)		28c. Injury at Work?	28d. Describe how	w injury occurred	
Division	Attanding r death. sctor: After by the funer	Certification:	2 Accident investigati 3 Suicide 6 Could not determine	be Oge Place of laite. At home	farm, street, factory	1 ☐ Yes 2 ☐ No y, office			Rural Route Number,
ă	ital or rs after rat Dire		4 ☐ Homicide determine	building, etc. (Specify)			City or Town,	State)	
,	Hosp 24 hou Funal	edical	29a. Certifier (Check only one) 2 Medical Exp	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.	lge, death occurred and/or investigation	at the time, date and p , in my opinion, death o	lace, and due to the ca occurred at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To the Hospital or Attandin, within 24 hours after death. To the Funaral Diractor: Att completely filled in by the fun	Me	29b. Signalure and title of certifier	110011/0/0	290	c. License number	29	d. Date signed (Me	onth, Day, Year)
	X		S M Man	www, park	in	N74160		0/14/2	(005
1	\		PETE HAVOVER	no completed cause of death (telin 23)	TEME (+	reet, Fall	incre, M	0, 2120/	
	Sta Registr		31. Date filed (Month, Day, Year)	2005 34 Registrar's Signature	Marke	/			

2005

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WEISS, JAMES

				ment of Health and Mental Hicate of Death	ygiene Reg. No. 2005 20120
	Physici /Medic		1. Decedent's Name (First, Middle, Last) HALLE WHITAK	2. Date of Month	2 14 2005 2025 PM
	Examin Funeral	ier	UNIVERSITY OF MARYUND MEDICAL (PUTRE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) III	City, Town, or Location of Death BUT NOZE Under 1 Year If Under 24 Hrs. 8. Date of to (Month, 09/23/	4c. County of Death A Birth Birth Pay, Year) 9. Birthplace (State or Foreign Country).
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio		1931 North Carolina 10d. Inside City Limits
	the Maryla 28a-f sho	ector	Maryland Baltimo		1 → Yes 2 No
	with of o	ā	1023 Poplar Grove Street	21216	U.S.A.
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or Items 23e or 28a-f show event, the Medical Exercity in util be mailful at	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Decedent of Hispanic Origin? (Specify Yes or Is, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify:	
21215-0	d within 72 ha giene. Ir than "netu	Completed by	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of working VOT use retired) 71fe	16b. Kind of Business/Industry Homemaker
Maryland	be be	To Be C	17. Father's Name (First, Middle, Last) Jimmy Lee Walker	18. Mother's Name (First, Midd Annie Hardy	lle, Maiden Sumame)
Mary	C1 10 - 8			ddress (Street and Number or Rural Route Num	
altimore, I	00	(8	Mary Ernestine Wilhite/Daughter 2416 N. 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State	n (Name of Date ry or other place)	imore, Maryland 21217 20c. Location - City or Town, State Landsdowne, Maryland
Baltin	permit, Pag Department Important: I eny injury o			me and Address of FacilinThe Derric	
	Fhysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.		
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	ANCER	
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate assections. Each of Larying Cause (Disease or injury that initiated events essulting in death) Last		
8760,	certificate be executed adding physician and use as the burial-transit	dlcal	Due to (or as a consequence of):		
O. Box 6	death e atter	Physician/Me		opic pregnancy ner (specify)	23d. Date of delivery Month Day Year
ecords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underly Revall Fallure	_	tobacco use contribute to the cause of death? Yes 2 2000 3 Probably 4 Unknown
T,	The ate h page	Completed			topsy prior to completion of cause of death?
Vital	i ician: T h certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	
ō	ding Phys n. After this funeral di	tlon: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 28d. Describ Work?	sidence 6 Other (Specify) e how injury occurred
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	factory, office 28f. Location	(Street and Number or Rural Route Number, own, State)
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence occurrence of my knowledge, death occurre	urred at the time, date and place, and due to th gation, in my opinion, death occurred at the tim	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To the To the Company of the Company	Σ	29b. Signature and title of confirier	29c. License number	29d. Date signed (Month, Day, Year)
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	TH GROOM STORE	THRE 14, 2005 T BALTIMORE, MARYLAND
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, and the same	A DACID-LOCAL TO COLO

05-3877 B.K.S KENNETH W. WENK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Media	an	Decedent's Name (First, Middle, La: KENNETH WAYNE WENK	,		-		2. Date of De.	6, Day 2005 Year	3. Time of Death
Examir		4a. Facility Name (If not institution, give 409 4th AVENUE	e street and number)		4b. City, Town, o			4c. County of Dea FREDERI	
Funeral Director		5. Social Security Number 6. S 220-58-6293	m m =	n yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bird Min. (Month, Da OCTOBER 6	th by, Year) 9. Bin Co 1952 MAR	thplace (State or Foreign buntry) YLAND
ms 23a or 28a-f show	ctor	10a. State 10b. County MD FREDER1		BRUNSWICK					10d. Inside City Limi
3a or 28 at by no	i Dire	10e. Street and Number 409 4TH AVENUE			10f. Zip Code 21726			10g. Citizen of What Co USA	ountry?
Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event. The Modical Extendent cust be notified at <u>once.</u>	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub.	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
glene. er than "natu	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ide completed) College (1-4or 5+) Ø	(Give	dent's Usual Occup kind of work done DO NOT use retire EQUIPMENT M	during most of d)	working	16b. Kind of Business	/Industry
h and Mental Hyglene. 7 Is marked other than "r traumatic event, Ine Mad	To Be C	17. Father's Name (First, Middle, Last) WOODROW W. WENK)				Name (First, Middle, E RUTH MAYS	Maiden Sumame)	
Ith and I	ľ	19a. Informant's Name/Relationship (DOUGLAS E. WENK / BR					r Rumal Route Numbe	er, City or Town, State, 2	Zip Code)
nt of Hea t: If item y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	ce) [Date	20c. Location - City or	
Departme Importen any injur- once.		21. Signature of Funeral Service Licer		IVY HILL	2. Name and Addre	ss of Facility	/11/05 FLECK FUNER ROAD, LAUKEI	AL HOME, INC. , MARYLAND 207	
nysician Medical xaminer	er er	shock, or heart Prure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hypertens Due to (or as a co		rosclerot	ic card	liovascu1a	r disease	Interval Between Onset and Death
Insit	i i	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of):					
nding physicien and use as the burial-transit	n/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):				23d. Date of de	iverv
by the attending ached tor use as	0) +	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of): oregnancy Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of del Month	ivery Day Year
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n. Atter this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Me	Cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	C. Due to (or as a co	onsequence of): regnancy]Fetal death 3[e of death 5[ot resulting in the u	Other (specify)	en in Part I. 26. Place of er: 4 □ Nursin	24a. Was autop performance of the performance of th	Month bbacco use contribute to fes 2 No 3 Pr an 24b. Were au prior to death? 2 No 1 79 Yes	Day Year o the cause of death? obably 4 / nknov utopsy findings availate completion of cause of
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ifer death. Director: Atter this certilicate has been signed by the attending in by the funeral director, page 2 should be detached tor use as	Certification: To Be Completed by Physician/Me	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as a condition of particle) 23c. If yes, outcome of particle birth 2 4 Pregnant at time 9 Unknown Ontributing to death but not particle birth 1 28a. Date of Injury (Month, Day Yes) 28e. Place of Injury	pregnancy] Fetal death 3 [e of death 5 [ot resulting in the unit of the second of t	Other (specify) Inderlying cause given the second of the	26. Place of er: 4 \(\text{Nursin} \) Nursin y at k? Yes 2 \(\text{No} \) No	24a. Was autop performed to the control of the cont	Month bbacco use contribute to fes 2 No 3 Pr an say prior to death? 2 No 1 To Yes tence 6 Mother (Special Control of the c	Day Year of the cause of death? obably 4 / Inknov utopsy findings availal completion of cause of ca
death. Stor: Atter this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Me	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co	pregnancy] Fetal death 3 [e of death 5 [ot resulting in the unit of the second of t	Other (specify) Inderlying cause given the second of the	26. Place of er: 4 Nursin y at k? Yes 2 No	24a. Was autop performed to the control of the cont	Month bbacco use contribute to fes 2 No 3 Pr an say prior to death? 2 No 1 Pr death? 1 Pr dence 6 Cother (Spectow injury occurred) Street and Number or Runn, State)	Day Year the cause of death? tobably 4 / Inknov atopsy findings availal completion of cause of the cause o

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CERTIFICATE #

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CERTIFICATE #

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Physician Medical Processor States (Post Mode), Labol Scanning Community and Community				State of Mary				lental Hyg	giene	
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Description of the continuous give stokes and numbers of the continuous give stokes and numbers of the continuous of the		Physicis		Decedent's Name (First, Middle, Last)	1.	*/ /				3. Jime or Destin
State disconting from the control of			al -	HNN	WI.	Hiam	5	Dine	4 Joas	21.420
Social Security Members 1.5 and 7.6 of the registery Members 1.5 and 7.6 of the registery 1.5 of the r				4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	O V	4c. County of Dea	ith
The content of the					tesptich	Baht	mone	City		
Use State Control of Development Total States	r	Funeral		10M 20E				8. Date of Birth (Month) Day	y, Year) 9. Bi	ountry)
100. Date 100. County 10		Director	- 1-		59 ^{rrs.}			SEPT 2,	1945	NC
The Section of the Company of the Co		pu ≱ost	-		c. City. Town or Lo	ecation				10d. Inside City Limits
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		1 - For State Registrar			cate of Death	Reg. I	21115 20121
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give s	Lee U) i i	2m S City, Town, or Location of Dec	JUNE 13,	Day Year 3. Time of Death 1506 Рм
Exami	ner	ST. AGNES HOSPITAL	areat and number)		ALTIMORE CITY	201	NIA
Funeral Director		5. Social Security Number 6. Sex 215-82-2778 15	M 2□F 7. Age (In yrs		Under 1 Year If Under 24 Hr inths Days Hours Min	n(Month, Day, Yea	9. Binhplace (State or Foreign Gunty) 961 Mary land
15-0036 72 hours after death with the Maryland "naturel", or frems 23s or 28s-f show	Director	Maryland . N/A	10c. C		vore		10d. Inside City Limits 1 ☑ es 2 ☐ No
with th		10e. Street and Number 2821 Kins	ey Avenu		0f. Zip Code	10g. (Citizen of What Country?
S after death or items 2	Funeral		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No	U.S. 13. Was	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
-003 hours a	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	163 Decedent	Lleual Conunction	16h	Specify: Black Kind of Business/Industry
Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tiern 27 is marked other than "naturar, or items 23a or 28a-f should among or other traumatic event, it we madical Examiner must be notified at once.	Completed	(Specify only highest grade	Completed) College (1-4or 5+)	(Give kind	of work done during most of w IOT use retired)	orking S	elf Employed
yland ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Johnny Jo	ne s		The	ame (First, Middle, Maid Ma	Morgan
Mar nd 2 sh th and 17 1s m		19a. Informant's Name/R- ationship (Ty)	oe, Print)	19b. Mailing Ad	Idress (Street and Number or I	Rural Route Number, City	141 21222
Baltimore, Maperer, Maperer, Pages 1 and 2 Department of Health a Important: if them 27 is any injury or other trangue.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		Place of Disposition cemetery, cremator	(Name of y or other place)	Market Committee of the	Location - City or Town, State
Baltimore, semil. Pages 1 ar Department of Hea mportant: If tem my injury or other and side.		'4 □Donation 5 □ Other (Specify) 21. Signature of uneral Service / cense		rinity Ce	me tiny (6)	31/2003 D	fundalk, MD
Bal permi Depa Impo		Tatelle \$;	Planis L.	M. 22	Seph Liku	h Ares 13	secto, MO 21216
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Narcotic Coc Due to (or as a conse	aine, and E	a mode of dying, such as cardi		Approximate Interval Between Onset and Death
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8760, rate be exect hysician and the burial-tra	m	that initiated events resulting in death) Last	Due to (or as a conse	equence of);			
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preging 1 □ Live birth 2 □ Fei 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ecto	opic pregnancy er (specify)		23d. Date of delivery Month Day Year
rds, P quires that on signed b	by	Part II. Other significant conditions con	stributing to death but not re	esulting in the under	ying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Record The law requir ate has been si	Completed					24a. Was an autopsy performed?	
Vita slcian: certific irector,	o Be	25. Was case referred to medical examiner?	lospital:	☐ EP/Outpatient 3		eath (Check only one) Home 5 - Residence	€ □Other (Secrital)
n of ng Phy iter this	-	27. Manner of Death	28a Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe how in	
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	2:26 P home, farm, street, cify)		28f. Location (Street City or Town, Sta Paltimore,	and Number or Rural Route Number, 2866 West Baltimore St
Hospita 24 hours Funeral	Medical C		sicien: To the best of my kr		urred at the time, date and pla gation, in my opinion, death oc	ce, and due to the cause	
To the within To the comple	Me	29b. Signature and title of certifier	A A O		29c. License number	29d. [Date signed (Month, Day, Year)
		20 Name and state of the	al A	am 22a) (Time - Direct	OCME	JU.	NE 14, 2005
		30. Name and address of person who co	HAY			t Baltimor	e, Maryland 21201
St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 6 2005	32. Registrar's Sign	nature			

amend i tem#10b-d, perFH, G844, 6/16/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE Day 2005 ear **Physician** 13, 5:30 WEISBERG Ам DORIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 8. Date of Birth Month, Day, Year) JUNE 23,1921 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 6. Sex 1□M 2☑F Months Days Hours 83 VΑ Director 220-09-2129 Usual Residence of Decedent 10a. State 10b. County N/A 10c. City, Town or Location 10d. Inside City Limits 28e-f shoy traumatic ayant. The Medical Examiner must be notified at 1X Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 7386 PARK HEIGHTS AVENUE 21208 USA or Itams 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. I □ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: à 3 ₩ Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER DENTAL LAB 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi **HANDEN** FLAX FANNIE SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 it any injury or other tra 7233 BROOKFALLS TERRACE - BALTIMORE, MD 21209 CHARLES WEISBERG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State VETERANS CEMETERY | 6/15/2005 OWINGS MILLS, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Toerto 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Recurrent LUNG Cances disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Hijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Cher (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 X ther (Specify) Naspice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one, and manner stated. within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58303 June 13 2005 0

State Registrar 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADRON Charles on 6601 N. Charles St Railtown MD 21204 32. Fegistrar's Signatur

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			For State Registrar		Maryland	/ Depa		t of H	ealth a		lentai Hy		005	20136
			Decedent's Name (First, Middle	e, Last)	-						2. Date of De	ath	Vaar	3. Time of Death
	Physicia /Medic		Mildred L. A	llen							June .	16, 2	2005 ^{Year}	8:50 a м
	Examin		4a. Facility Name (If not institution	, give street and num	ber)		•		Location of	of Death			ounty of Deat	
			Genesis Herit					unda		0.4.00			altimo	
	Funeral Director		5. Social Security Number 245–07–0684	6. Sex 7 1 ☐ M 2 🖾 F	. Age (In yrs. las	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da NOV •	b, 192	9. Birt Co N.	hplace (State or Foreign untry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	ō	Md. Balt	imore		Dunda	lk							1 ☐ Yes 2 🛣 No
	r 28a	rec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?
	72 hours after death with the Maryland naturel; or Iteme 23e or 28e-f show lical Examiner must be notified at	Funeral Director	1810 Belle Av	e.			212	222				USA		
	deat eme	ner	11. Marital Status	12. Was Deced	lent Ever in U.S.	. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	. 14	Race - Ame Black, White	
9	or Ite	F	1 Never Married 2 Marr		2 <u>₹</u> No	1	1 🗆 Yes		Specify:			Si	pecify: Whi	
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b	be filed within 72 hours after death with the Marylar ital Hygione. Id other than "naturel; or Iteme 23a or 28a-f show other than "naturel; or Iteme must be notified at event, the Medical Examine must be notified at	BeC	17. Father's Name (First, Middle,						18. Mothe	r's Nam	(First, Middle	, Maiden Su	ımame)	
Maryland 21215-0036	2 should be and Mental Is marked o eumetic eve	10 B	All the second of the second o	Bondura	ant	40b Meilie		/C4-0-04 =			cia Ric			Zin Cada)
	9 £ 1 = 0		19a. Informant's Name/Relations Gerald Aller								al Route Numb timore			пр Соде)
Baltimore,	or or		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 4 ☐ Donation 5 ☐ Other (S		tate cen	ce of Dispo metery, crem 'iew C	matory or c	ther plac	_{е)} Д	une	17, 2005		tion - City or imore	Town, State
Balti	permit. Pag Department Importent: I any injury c		21. Signature of Foneral Service	the state of the s		Ç	2. Name at pnnel	d Addres	s of Facili inera		me Of E Rd. 212	undal 22	k	
	•		23a. Part 1. Enter the disease, or	complications that ca	used the death.									Approximate Interval Between
	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. CER	EBRO	VA	SUL	AL	H	CC	IDE	NT		Onset and Death
	Examiner			b. ASP	r as a conseque	ence of):	'	Pole	ELPA	201	(11)			
$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	ir as a conseque	ence of): 2× ARTERY DISE/					ISEA	SE		
,092	te be executed ysician and te burial-transit	cal Exa	resulting in death) Last	Due to (c	PIA I	nce of):	BR/	51	AT	70	<i>^</i>			
687	, × 6			d.(2)	YBL	· / /	UN				/>			
.O. Box (The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Fetal d int at time of dea	leath 3[⊒Ectopic pi ⊒ Other <i>(sp</i>					23	d. Date of del Month	ivery Day Year
Q	ires that t signed by d be deta	by	Part II. Other significant condition	ons contributing to dea	ath but not result	ting in the u	inderlying o	ause give	en in Part I	•	23e. Did			the cause of death?
Records,	w requii been s should	Completed									24a. Was	an	24b. Were au	itopsy findings available
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<u>></u>	O N	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2 E	R/Outpatier	nt 3 DC	Othe	er: 4 1/4	ursing Ho	me 5 Res	idence 6[Other (Spe	cify)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date o	f Injury 2 n, Day Year) 2	28b. Time o Injury	of 2	28c. Injun Work	at k?		28d. Describe	how injury	occurred	
Sio	Attending r death. ector: After by the fune	catle	2 Accident investi	gation not be			М		Yes 2	No				
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 286. Place	of Injury - At hom g, etc. <i>(Specify)</i>	ne, farm, st	reet, factor	y, office				Street and i wn, State)	Number or Hi	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifyii	ng Physician: To the	best of my know	ledge deat	h occurred	at the tim	ne. date ar	nd place	and due to the	causa(s) a	nd manner as	stated.
	ne Hospite 124 hours ne Funerel eletely filled	edical	(Check only 2 Medical one)	Examiner: On the ba and mann	sis of examination	on and/or in	vestigation	i, in my of	pinion, dea	ith occur	red at the time,	date and p	lace, and due	to the cause(s)
	To the comple	Me	29b. Signature and title of certifie	er	~		29	c. License	e number	200		29d. Date :	signed (Mont	h, Day, Year)
•			Savinda	a K Jo	elle	MO)])2	718	18,		6/le	5/05	
	3		30 Name and address of person	who completed cause	of death (Item 2	23а) (Туре,	Print)	40	21.	. 7	V	of .	10 200	27
			31. Date filed (Month, Day, Year,	10/4	Sistrar's Signatu	M	arle	X	Plac	00	unda	IL M	1144	1
	Sta Regista		JUN 1	7 2005	Colors Signatu	d A	fazete							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / Day 2005 Month 14 June 4:08pM Margaret Allan

Physician /Medical **Examiner**

Director

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1 - For State Registrar

Funeral Director

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5-0036

Maryland 2121

Baltimore.

Box 68760.

Records, P.O.

Vital

of

Division

7 is marked other than "natural", or items 23a or 28a-f shov traumatic avant. The Modical Examinating the nutility at 12 should be filed within 7 h and Mental Hygiene. 7 Is markad othar than "n

Physician /Medical Examiner

burial-transit

Completed Be Physician/Medical ģ Be Completed dical Certification: To

Dolores 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Nov. 16, 1917 Maryland Months 1 □ M 2 🖫 F 219-01-4147 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Dorsey Ave. 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify.White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stewart's Sales Person 12th
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Edward Mattheu MAry Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Allan /son 4313 Sweet Bell Court Ellicott City MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore MD 6/18/05 Oak LawnCemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TA ME Stat Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

					1 ☐ Yes 2	Probably 4 □Unknown
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical				26. Place of Death (C	Check only one)	
examiner? 1 \(\text{Yes} 2 \text{No} \)	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 🗆 Nursing Home	5 ☐ Residence	S DOther (Specify) + SPICE
07 Manney of Dooth	29a Date of Injury	OOb Time of			Deceribe how injury	

1 195 22	10	1 Inpatient 2	ENOutpatient	3[] L	DOA 4 Nursing	arsing Home 5 Residence 6 Wother (Specify) 17 5/7				
27. Manner of Death 1. Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fy)	facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only 2 one)	Certifying Physical Examin	er: On the basis of my kno er: On the basis of examina and manner stated.	owieage, death ocation and/or invest	curre igatio	o at the time, date and place on, in my opinion, death occ	ee, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)				

1,25205

29c. License number

Jene 15 2005

29d. Date signed (Month. Dav. Year)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

Year

1 ☐Yes Ž∏No

of person who completed cause of death (Item 23a) (Type, Print) G-BATIC 6701

32. Registrar's Signature

N. Charle St. Balto und 21204

State Registrar

DHMH 17 Rev 1/2001

To tha Hospital within 24 hours a To tha Funeral C

THE STREET

			For State	State of Mar	yland / Dep		Health and N	fental Hygi	2005	20120	
			Registrar 1. Decedent's Name (First, Middle, Las	it)			Dealli	2. Date of Deati		3. Time of Death	
	Physici /Medio		NELSON H	OWARD	ALA	AN		Jy NE	Day Year	-12 45 M	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	OWN	4c. County of Death		
			NO CTHWEST 5. Social Security Number 6. So	HOSP17	In yrs. last birthday)	If Under 1 Year	17/100-1	· ·	SALT		
	Funeral Director			M 2□F 79	Yrs.	Months Days		8. Date of Birth (Month, Day, NOV 4 19	925 Md	nplace (State or Foreign untry)	
	yland iow		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits	
	e Mariat	ctor	Md Baltimor	e	Pikesvi	ille				1 ☐ Yes 2 🛣 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show important: If itam 27 Is marked other than "natural", or Itams 23a or 28a-1 show important: If itam 27 Is marked other traumatic avant. The Medical Evantural must be notified at ances.	by Funeral Director	10e. Street and Number 8901 Stone Creek	Place #102	2	10f. Zip Code 21208			og. Citizen of What Cou USA	untry?	
	tams	nner	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
36	rs afte	oy F	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Y es, Give Year or Dates:	WWII	1 ☐ Yes 2 🏌 No	Specify:		Specify: wh:	ite	
21215-0036	2 hou		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occu	pation	. 1	6b. Kind of Business/li	ndustry	
21	ithin 7 18. 18. Med	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work ad)	ing	financial		
121	iled w Hygier thar th		17. Father's Name (First, Middle, Last)	4	aco	countant	19 Mother's Nam	o /Eirst Middlo M	laiden Sumame) UV	\1\2	
/lanc	Mental Harked of	To Be	Tr. I allier 3 Hallie (First, Middle, Last)	UNV.			TO, WOUTER'S INALIT	e (Frist, Mildule, M	alderi Sumame) (LT		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after dea Obepartment of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items: may injury or other traumatic avant. the Medical Even in term once.		19a. Informant's Nama/Relationship (7 Shirley Alban (sp	^{Гуре, Print)} OUSE)					City or Town, State, Ziikesville,		
Jre,	of Hea itam		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date 2	Oc. Location - City or T	own, State	
Ë	Page ment c ant: If ury or		¹X☐ Burial 2 ☐ Cremation 3 ☐ ¹4 ☐ Donation 5 ☐ Other (Specify	Heilioval Ilolli State	Lake View	w Memoria	1 6-18-		ykesville,		
Baltimore,	permit. Departi Import any inj		21. Signature of Funeral Service Licen	+ Herber	4 P.	2. Name and Addr O. Box 1	^{ess of Facility} Hai .95 Sykesv	ght Fune	ral Home & 21784	Chape1	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	e death. Do not en	ter the mode of dy	ing, such as cardiac			Approximate Interval Between	
	Physician	i	Immediate Cause (Final disease or condition resulting in death)	a	DNB4	MONIA	7		4	Onset and Death	
	/Medical Examiner		1930iting in death)	Due to (or as a	consequence of):						
	30.13	je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):						
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c					-		
, 0,	sate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as a d	consequence of):						
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9 xo	death certifica attending ph of for use as the	//Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deliv	(env	
.O. Bo	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 2 (4□Pregnant at tin 9□Unknown		Ectopic pregnand Other (specify)	г у		Month	Day Year	
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Records,	quires an sign uld be	ed by	DEHYDRAT	ION RE	NAL ?	PAILY	RE	1 🗆 Yes	s 2 □ No 3 □ Pro	bably 4 Unknown	
၀၁	law requir as been si 2 should l	Completed	`					24a. Was an autopsy	24b. Were auto	opsy findings available	
E E	aician: The law certificate has t irector, page 2 s	Com						perform	ed? death? ☑No 1 ☐ Yes	ompletion of cause of	
Vital	Phyaician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		011	26. Place of Death	(Check only one			
of	Phy r this ral d	2 1 1 198 9 2 No 2 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
ion	nding P ith. :: After I e funera	27. Manner of Death 28a Date of Injury 28b. Time of Injury Work? 28b. Time of Injury Work? 1 Accident investigation 28b. Time of Injury Work? 1 Yes 2 No									
Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,	
	pital o		29a, Certifier 1 Certifying Phy	ysician: To the best of r	my knowladao dont	h anguard at the 1	in a data and alone	and due to the and	(-)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only one)	iner: On the basis of ex and manner stated	camination and/or in	vestigation, in my	opinion, death occurr	ed at the time, dat	te and place, and due t	o the cause(s)	
	To the To the Comp	Ř	29b. Signature and title of certifier	1		29c. Licens	se number		d. Date signed (Month,		
	4	03		1 Cen	-VV/	10.	5155	ک ک	UNE 15	, 2003	
	0		30. Name and address of person who c	11	th (Item 23a) (Type,	Print) ALTO.	MP 21	133			
ae	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 7 2005	32. Registrar's	Signature	وع					

			•	•		artment of Health and M		•	0.01.00		
			1 - State Registrar		Cei	rtificate of Death		g. No. UUD	20139		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Nellie	Katherine	Abı	recht	2. Date of Death June 1	4, 2005 ^{ar}	3. Time of Death 6:48 P. M		
	Examin		4a. Facility Name (If not institution, give str 750 Carroll Parkwa		В	4b. City, Town, or Location of Death Frederick		4c. County of Death	ederick		
	Funeral Director		5. Social Security Number 6. Sex 1 Number 6. Sex	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	0, 1934 9. Birth	place (State or Foreign laryland		
			Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation			10d. Inside City Limits		
:	e Maryis te-f sho liffed a	ctor	Maryland Freder			Frederick			1X Yes 2 □ No		
:	n with the	Funeral Director	750 Carroll Parkway	, Apt. 10-B		10f. Zip Code 21701	10	og. Citizen of What Cou U.S.A.	ntry?		
020	permit. Plages 1 and 2 should be liled within 72 hours after death with rine maryland Department of Health and Mential Hygiene. Importment of Health and Mential Hygiene. Inacreatit if litem 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic avant, Items	þ	11. Marital Status 12 1 ↑ Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i	Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh			
2-0-1	nin 72 no e. an "natur Modical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)		6b. Kind of Business/Ir			
7	ygiene ygiene yar tha t, II.e.	Соп	10		Telep	hone Operator		Telephone (Company		
yand	ould be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Clyde Smith Abrec	ht, Sr.		18. Mother's Name Wilmoth	i (First, Middle, M Ida Adai				
Mai	alth and 27 Is my 1.27 Is my sr traum		19a. Informant's Name/Relationship (Type Douglas F. Abrecht/			ng Address (Street and Number or Rure Runnymeade Drive					
	Pages 1 annent of He Int; If itam Iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crer thsburg	osition (Name of matory or other place) Crematory June 16	5, 2005	oc. Location - City or T Smithsburg	own, State 5, Maryland		
	permit. Departing Imports any inju		21. Signature of Funeral Service Licensee	//a // // N/	00021	Name and Address of Facility Keeney and Basfor	rd Funer	al Home	NO 01701		
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the decause on each line.	ath. Do not ent	er the mode of dying, such as cardiac of	or respiratory arre	frederick,-	Approximate Interval Between Onset and Death		
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	equence of):	LEV .			year		
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	te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause End of Unique Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
00/00	physicia properties the puri	cal	d.								
O. DOX	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	a. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year		
r,	uires that signed b ild be deta	by	Part II. Other significant conditions contr	ibuting to death but not re	esulting in the u	nderlying cause given in Part I.		acco use contribute to t	he cause of death?		
	sician: The law requir certificate has been si irector, page 2 should	Completed					24a. Was an autopsy perform	prior to co led? death?	opsy findings available impletion of cause of		
VII	cran: ertific ector,	Be	25. Was case referred to medical examiner?	spital:		26. Place of Death	The second second				
5	Phy this rald	on: To	1 Tyes 2 TNo 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	□ ER/Outpatier 28b. Time o Injury	f 28c. Injury at Work?	me 5 🖪 Resider 28d. Describe hor	nce 6 Other (Special of the control	(5)		
DINISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,		
	Hospita 24 hours Funaral stely filled	edical Co				h occurred at the time, date and place, vestigation, in my opinion, death occurr					
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifie	and marrier states.	· · · · · · · · · · · · · · · · · · ·	29c. License number	29	d. Date signed (Month,	Day, Year)		
		3	30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type,	Print) Tou House An		6 76 6 5	0		
	Q		31. Date filed (Month. Day, Year)	MA 32. Rahistrar's Sin	801	10ch trouse to	in me	Unich M	/)		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 7 20	05 Acres	A A	Soule					

			State of Maryland / Dep	artment of Health and Mertificate of Death	•	7005 20140
	Physici	an	Dorothy Virginia Ausherman 1. Decedent's Name (First, Middle, Last) Dorothy Virginia Ausherman	Turiodic or Dodin	2. Date of Death	Dax 2005 Year 3. Time of Death 5:30 AM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Beverly Health Care Center	4b. City, Town, or Location of Death Frederick	,	4c. County of Death Frederick
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth (Month, Day, Ye Nov. 19,	
	show	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L. M. J. J. J. T. J.	ocation		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th the Mi	Irecto	Maryland Frederick Frederi 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	eath wi	eral	5107 Shookstown Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21702 Was Decedent of Hispanic Origin? (Spe	city Yes or No-	U.S.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumetic event, Ite Medical Ext. ultrer: ust be ricilited at once.	d by Funeral Director	1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036	within 72 h ane. than "natu	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workil DO NOT use retired) Homemaker	ng	o. Kind of Business/Industry Own Home
and 2	l be filed ntal Hygie ed other event, II	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Main	
laryl	2 should and Mer is mark eumatic	2	7	ing Address (Street and Number or Rura	l Route Number, Ci	
	is 1 and of Health item 27 other tr		Mrs. Jeanette E. Stillrich, Daughter 20a. Method of Disposition 20b. Place of Disposition 20c. Method of Disposition	5107 Shookstown Ro		erick, MD 21/02 c. Location - City or Town, State
altimore,	iit. Page artment c ortent: If injury or		'4 □ Donation 5 □ Other (Specify) Mount Oliv	vet Cemetery June 1		Frederick, MD
Ba	Depar Depar Impor any ir		Prichard MO0255 K	2. Name and Address of Facility eeney and Basford 1 06 East Church Stre	PA Funera eet, Fred	l Home erick, MD 21701
	Pnysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause University in the cause of the ca			
,092	ate be executed hysician and the burial-transit	Ical Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
89	ertificate ing phys e as the	g	IF FEMALE:			
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 1 2sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Ω.	quires that the dei n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	The taw requir Ite has been si age 2 should	Completed			24a. Was an autopsy performed 1 Yes 2	
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death	(Check only one)	
on of	Attending Physicien: The lar r death. r death. sctor: After this certificate has by the funeral director, page 2	lon; To	27. Manner of Death 28a. Date of Injury 28b. Time of Month, Day Year Injury Injury	of 28c. Injury at 2 Work?	28d. Describe how in	e 6 ☐Other (Specify) injury occurred
Division of Vital	• Hospitel or Attenc 24 hours after death • Funerel Director: etely filled in by the 1	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
.	To the To the comple	Me	29b. Signature and title of certifier	29c. License number		une 13, 2005
	n < 1		30. Name and address of person who completed cause of death (Item 23a) (Type,	D0060417		
	Sta	te	HEMEN SHAH, 65-C THOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature	JOHNSON DV.	FRBDO	WICK MD 21702
	Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de)		

amend 7 per KBH per BC g855 5/11/06 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Baby Girl Brownlee-Smith State of Maryland / Department of Health and Mental Hygiene NJM Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Baby Girl Brownlee-Smith May 2005 1530 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthday)
Yrs. Vers. Index 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day)
Months Days Hours Min. (Month Day)
May 29, Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Maryland **Director** none Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "neturel", or Items 23a or 28a-f show ury or other traumatic event. In Medical Evant in a must be notified at ury or other traumatic event. In Medical Evant in a must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₹ No Funeral Director Prine Georges' Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pennsylvania & Silver Hill Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 Widowed 4 Divorced black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Iesha Brownlee-Smith P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. lll Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. ்4 □Donation 5 ☑Other (Specify) in state 21. Si matur of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately

Approximat Approximate Interval Between Onset and Death Immediate Cause (Final Physician placental abrustian a. Multiple my unies complicated by troumatr' disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of teath? 2 No Yes 2 🗆 No the Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 🙀 ER/Outpatient 3 ☐ DOA Other: 2 1 ¥ Yes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) tuneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After Injury 1 Natural 5 Pending motor vehicle accident 1:50 1 ☐ Yes 2 🕱 No death. 2 Accident 3 ☐ Suicide 28e. P M 1 P investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pennsylvan, a tree + Silver Hill Rd, Swattand, H.D. filled in by 4 Homicide Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fun completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ast OCME May, 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 1

a 31. Date filed (Month, Day, Year)

Tash

2002 Registra Signature

111 Penn Street Baltimore, Maryland 21201

			For State Registrar	State o	f Maryla	-	artment or rtificate o				g. No.	05	20112
f	Physicia /Medic		1. Decedent's Name (First, Middle, Last, Peggy F. Boinis							2. Date of Deat Month 06	Day	Year 005	3. Time of Death 9:12a M
L	Examin		4a. Fecility Name (If not institution, give	street and nu	mber)		4b. City, Tow	n, or Location Chase		-		nty of Death	
Ī	Funeral Director		5. Social Security Number 6. Security Number 109-26-2232	M 2[XF	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Ye Months Da	ar If Under		8. Date of Birth (Manth Day,		9. Birth	place (State or Foreign ntry) nsylvania
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Mont got	nery		City, Town or Lo							10d. Inside City Limits 1¥ Yes 2 ☐ No
	vith the	Direc	10e. Street and Number				10f. Zip Cod		_	11	0g. Citizen o	f What Cou	ntry?
920	2 should be filed within 72 hours effer death with the Maryland and Mental Hygiene. is marked tother then "neturel; or items 23e or 28e-f show eumetic event, the Madical Examiner must be notified at	by Funeral Director	105 Newlands St. 11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2 X No ve	1	Was Decedent of Yes, specify C		igin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		ace - Ameri lack, White, city: Wh	
Maryland 21215-0036	ed within 72 ho giene. er then "netur ; the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re emaker	ne during mos tired)		ng		wn Hon	ŕ
land	should be file and Mental Hy s marked oth umetic event	To Be	17. Father's Name (First, Middle, Last) George Raymond Fo	gelsor	nger					(First, Middle, M Elizabe			
2	121를 5		19a. Informant's Name/Relationship (Ty George A. Boinis		ınd					Route Number, evy Chas			p Code)
altimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from		Place of Dispo Resapea				6-2005	Belts	n - City or T SVILLE	
Balt	permit. Departr Importe any inji		21. Signature of Fungral Service Ligens	am	Moo.					emation er Sprin			
Ã	Pnysician /Medical		23a. Part1. Enfer the disease, or compi shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on o	each line.	Cancer		dying, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death 6 months
	te be executed ysician and burial-transit and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last)	(or as a conse								
9289	2 0	Medical											
.O. Box	The law requires that the death certifical ite has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live I	tcome of preg pirth 2 Pe nant at time of own	tal death 3	Ectopic pregna Other (specify					Date of deliv Month	ery Day Year
rds, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions co	ntributing to d	eath but not re	esulting in the u	nderlying cause	given in Part	l.				he cause of death?
al Records,		Completed								24a. Was an autops perform	ned?	o. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
Žį.	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA			<i>(Check only on</i> ne 5 ⊠Reside		ther (Specia	fv)
Division of Vital	ding h. Afte fune	ation: T	27. Manner of Death 1 X Natural 5 Pending investigation		of Injury th, Day Year)		f 28c. i	njury at Work? Yes 2	2	28d. Describe ho			77
DİVİ	in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface build	of Injury · At ing, etc. (Spec	home, farm, str cify)	reet, factory, off	Ce	2	28f. Location (Sti City or Town		mber or Run	al Route Number,
	To the Hospitel within 24 hours a To the Funerel C completely filled	Medical	29a. Certifier (Check only one) 15 Certifying Phy 2 Medical Exami	ner: On the b	e best of my k easis of examin ner stated.	nowledge, deat nation and/or in	h occurred at th vestigation, in r	e time, date a ny opinion, de	nd place, a ath occurre	and due to the ca ed at the time, da	use(s) and rate and place	manner as s e, and due t	stated. o the cause(s)
)	To the To the Comp.	M	29b. Signature and title of certifier					ense number 0002360	10	29	9d. Date sign	ned (Month, 5-2005	
	10		30. Name and address of person who con Bruce Kressel 553	ompleted cau 30 Wisc	se of death (it	_{ет 23а) (Туре,} Ave #11	Print) 25 Chev	y Chas	e MD	20815			
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 7 2	005 32. F	Registrar's Sig	nature	berte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary June 13, 2005 /Medical 9:05 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood at Crumland Farms Frederick Frederick 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 💢 F Hours Min 219-52-1172 Director 87 Jan. 5, 1918 | Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov Tra Nedical Examinar must be notified at Funeral Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Frederick 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care othar or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finance and Mental H 2 William Calvin Humm Pearl Eyler 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a William N. Balm, husband 218 Norva Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 17, 2005 permit. Page Department of Important: If any njury or once. * 4 □ Donation 5 □ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 21. Signature of Funeral Service Jicense 22. Name and Address of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 21701 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5-70ays Drew manior /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 51 PNO 515 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DISEC. YOUNCEN artem 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one: 1 ☐ Yes 2 No

Division of Vital Records, P.O. Box 68760 2 Certification: After death. in by the Diractor: To the Hospital within 24 hours a

noun to yohnsicans

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and manner stated

5 Pending investigation

6 ☐ Could not be

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Dav. Year)

Shop Hiren

D51643

June 15, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas

27. Manner of Death

1 Natural 2 Accident

3 🗀 Suicide

4 Homicide

31. Date filed (Month, Day, Year) JUN 1 7 2005 Believe It forthe

Thonson 38 Registrar's Signature

Frederick and 21702

State Registrar

Medical

	1	For State Registrar	State of Man		artment of hartificate of		-	giene Reg. No.)5	20141	
Physiciar /Medica Examine	n al -	1. Decedent's Name (First, Middle, Last) Robert George Benson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, o				or Location of Deat			h Day Year 3. Time of Death 11:19p h		
Funeral		Holy Cross Hospital 5. Social Security Number 359-05-4987 6. Sex 7. Age (In yrs. last birthday) 1 M 2 D F 85 Yrs.			Silver Spring			Montgomery of Birth th. Pay, 1987 17. 1919 9. Birthplace (State or Foreign Country 11. 11. 11. 11. 11. 11. 11. 11. 11. 11.			
Director show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li								0d. Inside City Limit	
th with the 23a or 28a	Funeral Director	10e. Street and Number 10427 Eastwood Ave						10g. Citizen of V	J. Citizen of What Country?		
urs a	ρ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	les? 1942 If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 ₺ No Specify:			pecify Yes or No- Drican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White			etc.	
e filed within 72 h al Hygiene, l other than "natu vent, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Cach				kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry DC Public Schools		
should be file and Mental Hy, transfer other umetic event,	To Be	17. Father's Name (First, Middle, Last) Norton Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route					e Seidel				
Health a tem 27 is other tree		Joyce Benson (v	vife)		27 Eastw	ood Ave			D 209	01	
permit, Pages Department of I Importent: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	ee	Chesapeak	te Cremat 2. Name and Addre Rapp Fun	ory 06- ess of Facility eral & C Ave Silv	17-2005 remation	Belts	2	, MD	
ysicia ne bur	ical Ex	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Interval Between Onset and Death Due to (or as a consequence of): Chronic Congestive Cardiomyopalty Due to (or as a consequence of): Chronic Congestive Cardiomyopalty Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
death certific e attending pid for use as t	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown					23d. Date of delivery Month Day Year			
es the	ر و	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bladder Carcinma						3.9. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
	Completed	Type 2 Diabetes Méllitus Dementia Chronic Renal Failure					perfo	autopsy performed? prior to completion of cause of death? Yes 2₺ No 1 ☐ Yes 2 ☐ No			
ng Physicie ifter this cert ineral direct	0	25. Was case referred to medical examiner? 1	28a. Date of Injury 28b. Time of 28c. Injury at Work?				th (Check only one) lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
the Hosp in 24 hou the Fune apletely file	edic										
5 with		29b. Signature and title of certified Lead MD 30. Name and address of person who completed cause of death (Item 23a) (Type,			0055522			29d. Date signed (Month, Day, Year) $6-15-2005$			
0		30. Name and address of person who co Robert H. Gerard				w Carina	MD 2091	Ω			

State of Maryland / Department of Health and Mental Hygiene UU 5

1- Statemend Item #12 Per INF G851 1/09/Afficatte of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 06/ James Francis Buskirk 13/ 2005 8:15 PM M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care - Ruxton Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Director <u>213-26-2149</u> 12/28/1931 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other then "neturel", or Items 23e or 28e-f sho treumatic event, the Modical Exerciper must be notified at Director 1 ☐ Yes 2 X No Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4310 Piney Park Road 21128 12. Was Decedent Ever in U.S.
Armed Forces?

To Yes 2 The Korean
If Yes, Give
Year or Date Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Steel Worker Bethlehem Steel Co. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mental H tem 27 Is marked ott Mary Cecelia Hoffman James Buskirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Elizabeth B. Buskirk (wife) 4310 Piney Park Road - Perry Hall, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith cem. 06/16/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 11750 Belair Road - Kingsville, Maryland 21087 assala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4⊡Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been signe should be o Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? 1 Tes 2 110 To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check on one Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 27. Manny of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and titler of certifier 29d. Date signed (Month, Day, Year) 2-0012849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLERDI TOUSON MD 1660 Gull ADI. MD. 2. Registrar's Signature 31. Date filed (Mont 7702005 State

Registrar DHMH 17 Rev 1/2001

				1- For State of Maryland / Department of Health a Certificate of Death			giene 0 0 5	20146
		Physici		1. Decedent's Name (First, Middle, Last) Alice Matilda Barantas	2.	Date of Dea Month June	Day Yea	3. Time of Death
		/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of RUVORSIALS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□ M 2対 74 Yrs. 4b. City, Town, or Location of BUCAM 1f Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8.	Date of Birt (Month, Da)	4c. County of De	inthplace (State or Foreign Country)
				Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		./14/1	931 ME	10d. Inside City Limits
5		ith with the Marylar 23a or 28e-f show	ctor	MD Harford Edgewood				1 □Yes 2√1No
A		with the	Dire	10e. Street and Number 10f. Zip Code 21040			10g. Citizen of What	
ARAN	5-0036	s after des or iteme	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orig tf Yes, specify Cuban, Mexican, 11 □ Yes 2 ☑ No 11 □ Yes 2 ☑ No 11 □ Yes 2 ☑ No		y Yes or No- an, etc.)		nerican Indian, nite, etc.
BAI	215-0		To Be Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most life. DO NOT use retired)	st of working		16b. Kind of Busines	ss/Industry
	12121	be filed within ital Hygiene. id other than "evant, It e Mes	Com	Etementary/Secondary (0·12) Cotlege (1·4or 5+) Seamstress 17. Father's Name (First, Middle, Last) 18. Mother	or's Namo (Fi	ient Middle	Clothing	
R	Maryland	2 should be for and Mental His marked of reumatic evaluations	To Be		ilda B		maiden Sumame)	
fu	Man	s 1 and 2 should f Heelth and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Fred Barantas/Husband 57 Little Creek La				
16	ore,	0 0		20a. Method of Disposition 1 □ Spurial 2 □ Cremation 3 □ Removal from State	Date		20c. Location - City	or Town, State
AK	altimore,	그는문문		'4 □Donation 5 □Other (Specify) Gardens of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	6/17/ ^b Mill	-		, Maryland al Home Inc.
	ä	Depa Impo any ir		6415 Belair Roa	ad Bal	timor	e, Marylan	d 21206
		Physician /Medical Examiner		23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only not cause on each line. Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of):	cardiac or re		rest,	Approximate Interval Between Onset and Death
B	8760,	icate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
	P.O. Box 6	or Attending Physician: The law requires that the death certific that death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morphs? 1 Yes 2 Vec 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of d Month	elivery Day Year
	ds, P	w requires that s been signed b s should be dete	by	Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did to	1	to the cause of death?
	Division of Vital Records,	: The law requ cate has been , page 2 shoul	Completed			24a. Was a autop perfor	an 24b. Were prior to	
	f Vita	ysician: Th is certificate director, pag	To Be	examiner?	of Death (Clursing Home		ence 6 Other (Sp	ecify)
	ion of	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification; T	27. Manner of Death Salar Date of Injury 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 N	28d.		ow injury occurred	
	Divis	el or Atte s after de il Directo d in by tl	ertific	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,
		To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and th occurred a	due to the cat the time, o	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier 29c. License number		2	29d. Date signed (Mo.	nth, Day, Year)
		Gi		30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)	,		6/15/0	
		1		noun Arcuno un 615 Nacohail 1	10 19	Bul 1	ly An.	21014
		Sta Registr		31. Date filed (Morlin, Day, Year) 2 32. Registrar's Signature JUN 1 7 2005				

				partment of Health and Mertificate of Death	lental Hygie	/11115	20147
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Dav Year	3. Time of Death
	/Media		Yolanda Barber		June 12,	2005	12:30A M
	Examir	er	4a. Facility Name (If not institution, give street and number) 5217 Hazelwood Avenue	4b. City, Town, or Location of Death		4c. County of Death	
	Formul		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Baltimore Baltimore Balti	8. Date of Birth	N/A	place (State or Foreign
н	Funeral Director		217-26-8010 1 M 2X F 72 Yrs.	Months Days Hours Min.	11/2/1932	er) Coul	yland
	pr ,		Usual Residence of Decedent				, addite
	arylar show	-	10a. State			1	Od. Inside City Limits
	he M	Director	10e. Street and Number	imore			1 X Yes 2 No
	with is or	בו	5217 Hazelwood Avenue	10f. Zip Code 21206	10g.	Citizen of What Court U.S.A.	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madigal Examinat must be rollified at	Completed by Funeral			cifv Yes or No-	14. Race - Americ	an Indian
ဖ	after or He	Fur	1 Never Married 2 Married 1 Yes 22 No	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White,	
9	ural',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21 ☐ No Specify:		Specify: Wh	ite
<u>7</u>	"natu	lete	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Git	cedent's Usual Occupation we kind of work done during most of working b. DO NOT use retired)	ng 16b	. Kind of Business/In	dustry
7	withli lene. than	d mo	Elementary/Secondary (0-12) College (1-4or 5+)	eamstress		Tailor	
<u>0</u>	illed Hygi othar ant, I	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be redified at ance.	To B	Gabriele DiPasquale	Rose G	enovese		
ar	2 sho and h Is ma			iling Address (Street and Number or Rura)			
	and ealth m 27))		15 Ipswitch Drive B			
altimore,	Pages 1 nent of H int: If ita		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)		. Location - City or To	
	rtmen rtant: njury	. 9		of Faith 6/14		ltimore, h	•
Ba	permit. Departm Importa any inju	li is		22. Name and Address of Facility Mi 6415 Belair Road Ba			
П			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,	0	Approximate Interval Between
	Prrysician /Medical	N I	Immediate Cause (Final disease or condition resulting in death)	GASTIC CANCE	ER	_	Onset and Death
	Examiner		Due to (or as a consequence of):				, , , ,
		ier	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
K	be executed sician and burial-transit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events				
Ó	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	ate ohy:	dical	d				
9 X0	death certific e attending p od for use as	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy				
Bo	atten for us	Physician/Me	in the past 12 months?	Ectopic pregnancy		23d. Date of delive Month	ry Day Year
o.	0 0 0	ysic	1 Yes 2 No 9 Unknown 9 Unknown				
S, D	requires that the een signed by th hould be detache	by Pi	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
īg	equire en sig ould b				t □ ¥6s	2 □ No 3 □ Prob	abły 4 □Unknown
Record	> 0 70	plet			24a. Was an autopsy	24b. Were autor	osy findings available
Ĭ	The ate h page	Completed			performed	? death?	npletion of cause of
Vital	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	Check onl one		
	Phys this al dii	T0	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	The second secon	ne 5 Residence	6 ☐ Other (Specify)
U O	iei iei	tlon	Natural 5 Pending (Month, Day Year) Injury		8d. Describe how in	ijury occurred	
Division of	or Attanding after death. Director: After in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s		8f. Location (Street	and Number or Rura	Route Number.
á	al or safter	Certification:	4 Homicide determined building, etc. (Specify)	, ,	City or Town, Sta	ate)	,
	To the Hospital or Attandit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de: (Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, ar	nd due to the cause	(s) and manner as st	ated.
	the H hin 24 the F nplete	Medical	one) and manner stated.				
	viti Con	Σ	29b. Signature and title or certifier	29c. License number		Date signed (Month, L	
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	5			ANDPIPER CIR	CLEIN	10-21	042
	Sta Registr	187	31. Date filed (Month, Day, Year) 32. Registrar's Signature	re de la companya de la companya de la companya de la companya de la companya de la companya de la companya de			

		State of Maryland / Department of Health and Mental Hygiene	
_		1- State Registrar Certificate of Death Rag No. 0 5 2	0148
Physici /Medic Examir	cal	MARGARET CHARLOTTE BIGGERMAN JUNE 13 2005	3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 M 2 F 87 Vrs. AND DE GRACE HAR- FO Country, Months Days Hours Min. Month, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year) When the property of Decedent HAR- FO Country, Manth, Day, Year Manth, Day, Yea	ond on (State or Foreign LAND
death with the Maryland ms 23a or 28e-f show	Director	10a. State 10b. County 10c. City, Town or Location 10d.	. Inside City Limits 1 ☑ Yes 2 ☐ No
9 # # #	by Funeral Di	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcess 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc	TATES
Maryland 21215-0036 the administration of 2 should be filled within 72 hours after that administration of 27 is marked other than "netural", or treumetic event, the Modical Example	Completed b	Specify Only highest grade completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus 16b. Kind of Business/Indus 16c. NOT use retired	
and be filed that Hygodothe	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	CIOCI
aryla should nd Mer marke marke	2	2 CHARLES B1GGERMAN MARGARET CHANEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	ode)
and 2 and 2 ealth a m 27 is		RICHARD CHANEY COUSIN 9 SANDERS CT. BLUFFTON, SC 2990	9
nore ages 1 ant of H ont of H y or oth		20a. Method of Disposition 1	, State
Baltimore, permit. Pages 1 at Department of Hea Importent: If ten any injury or othe one.		21. Signat #9 of Fig. ral Service Licens #2 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122	MD
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	oproximate terval Between nset and Death
60, A be executed to be executed burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.	
MARMARKES REST REST REST REST REST REST REST RE	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	y Year
ecords, P	þ	Part ii. Other significant conditions continuoung to death out not resulting in the underlying cause given in Part i.	
W A N N N Vital Rec	e Completed	1 Yes 2 TNO 1 Yes 2	etion of cause of
of Vi	To B	examiner? 1	-
Division of Vital Division of Vital To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Certification:	27. Manny of Death 1 Valuated 5 Pending (Month, Day Year) 28b. Time of Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined determined 1 Suicide 2 Suicide 2 Suicide 3 Suicide 2 Suicide 3 Suicide 2 Suicide 3 Suicide	
Div Div safter el Direce el Direce	Certif	4 Homicide determined determined determined building, etc. (Specify)	ute Number,
the Hospil in 24 hour the Funerr pletely fills	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	d. cause(s)
Tour	Σ	Hi 4up 9im M.D. P464/2 6/13/05	, Year)
φ		39*Name and address of person who completed cause of death (Item 23a) (Type, Print) H GWD GIM 219 5- (MM) N AVT HD6 MD 310 7-8	
Sta Registra			

			1 - For State Registrar	State of	Maryla	nd / Depa <i>Cei</i>	artmer <i>rtificat</i>					giene Reg. No.	105	20149
	Physic /Medi		Decedent's Name (First, Middle, La	Mable (ware					2. Date of De Month June	Day	2005	3. Time of Death 5:30 A M
	Examir	ner	4a. Facility Name (If not institution, given Suburban Hospita		ber)		4b. City,	Town, or Beth	Location o	of Death			ounty of Death	
	Funeral Director		Social Security Number 6.		. Age (In yrs 78	. last birthday) Yrs.	If Under Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da June 30	th.	9 Righ	place (State or Foreign intry) ryland
	Maryland 9-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	nerv	10c. C	ity, Town or Lo Rock	cation Ville	9						10d. Inside City Limits 1X Yes 2 □ No
	with the	Director	10e. Street and Number 4619 Creek Shore				10f. Zip		. 0			10g. Citizer	of What Cou	intry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id office than "natural", or items 23e or 28e-f show event. The Modical Examination matter matter matters.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? ⊠ No		Was Deced f Yes, spec 1 ☐ Yes	cify Cubar	spanic Orio	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)	- 14.	ed State Race - Ameri Black, White, ecify: W]	ican Indian,
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, I're Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2	ade completed) College (1-4	lor 5+)	Senio	kind of wo DO NOT u	rk done d se retired) 11010	uring most	of workir	og .		of Business/Ir	ndustry
yland	ed al	To Be	17. Father's Name (First, Middle, Last George Cline						1	Mary	(First, Middle, Ann Ba	rnes		
Mai	nd 2 still ar ar 27 is		19a. Informant's Name/Relationship (Ray P. Benware/Hu								Route Numbe			o Code) nd 20852
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		ate	Place of Dispo- cemetery, cren	sition (Nam natory or o	ne of ther place)		18.	20c. Locati	on - City or To	
Balti	pernit. Page Dep riment of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee		R ₀ ²²	Name an	Addres	of Facility	y cev F	unaral	Ното	Doolerei	lle, Inc. 0850-2805
	Enysician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	ised the dea th line.	th. Do not ente	er the mod	e of dying	, such as	cardiac or	respiratory ar	rest,	3	Approximate Interval Between Onset and Death
	/Medical Examiner	-E	resulting in death) Sequentially list conditions, if any leading to immediate	Due to (or	as a consec c Shoc as a consec	quence of):							7	days
68760,	icate be executed physician and s the burial-transit	edicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Urina		ct Inf	ectio	on					8	days
.O. Box	death certil e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outco 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2∏Feta tat time of c	al death 3	Ectopic pro Other (sp					23d.	Date of delive	ery Day Year
rds, P	law requires that the das been signed by the	ρ	Part II. Other significant conditions of Acute Renal Fa		h but not res	ulting in the un	derlying ca	ause giver	in Part I.					ne cause of death? pably 4 図Unknown
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Vita	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	atient 2	ER/Outpatient	3□ DO	Othor			(Check only or		Other (Consider	
	ding h. After fune		27. Manner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,		28b. Time of Injury		8c. Injury a Work?		28	Bd. Describe h			//
Division	2 # 5 0	Certification:	3 Suicide 6 Could not b	building	etc. (Specif					-	City or Town	n, State)		l Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the be niner: On the basi and manner	s or exam≀na	owledge, death ation and/or inv	occurred a estigation,	at the time in my opi	, date and nion, death	l place, ar n occurred	nd due to the c d at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
þ	To th Withir	Me	29b. Signature and title of certifier 12 CVCM	mD.		44.4		License	olo:	31	2	9d. Date sig	ned (Month, I	-
	Ü		30. Name and address of person who Natasha Chen, M.I	o. 8600 (Old Ge	orgeto	wn Ro	ad,	Bethe	sda,	Maryla	ınd 20	814	
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	1 7 200500	strans Signa	iture &	600	de						

Benware, mabel objestor 0530 A.M.

State of Maryland / Department of Health and Mental Hygiene UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Oeath 3. Time of Death **Physician** 13°, 2005 JUNE BERGMAN 4:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) NOV. 10, 1904 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 📆 F Yrs. Director 218-32-3649 100 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show treumetic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or Items 23a 6807 PARK HEIGHTS AVENUE #4-D 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after inent of Health and Mental Hygiene. Instite If item 27 Is marked other then "naturel", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLER TINDECO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ISRAEL SCHWARTZMAN** SARAH BROWN ౖ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 SLADE AVENUE #509 - BALTIMORE, MD 21208 H. ROBERT BERGMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HEBREW FRIENDSHIP CEM 6/16/2005 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC.) ou 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician ALZHEIMER'S DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical nding p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Certification; To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) Karen J. D0058676 JUNE 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babitt M.D. 25 Main Street, suite 200, Reisters bown, MD 21136 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 7 2005

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1- State MEND ITEM #19b PER FH G844 6/28-/000 care of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Margaret Virginia Ciarpella 2005 5:00 A June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rossville Baltimore Manor Care Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours Min. 1 ☐ M 2 👿 F 74 Yrs Director 212-28-6004 1930 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Baltimore Edgemere Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7908 Shore Road 21219 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "naturel", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Henderson Farrell Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Ciarpella, 7908 Shore Road, Edgemere, Maryland 21215 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of once. Gardens of Faith Cem. 6/11/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee ail 3331 Brehms Lane, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cardie week /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-transit that the death certificate be executed Cerebra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 🗙 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 4940 Easter 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For Amend Item 20	State of Maryland a-c per me 684	4 Gepa Cer	rtment of H tas tificate of L	ealth and N Death	fental Hygie	ne № ೧೧5	20152
		4	1. Decedent's Name (First, Middle, Last)					2. Date of Death	-	3. Time of Death
	Physici /Medic		Timothy Dee Cator	1				JUNE	14, 200	5 1:30F M
	Examin		4a. Facility Name (If not institution, give Saint Joseph M		r	4b. City, Town, or	Location of Death Towso	n	4c. County of D Bal	timore
	Funeral Director		213-80-0815	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 04/15/196	ar)	Birthplace (State or Foreign Country) Jaryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Fown or Lo	cation				10d. Inside City Limits
	Marylan f ehow ied at	ю	MD Baltimo	ore Gle	n Arm					1 ☐ Yes 2X No
	r 28e	rec	10e. Street and Number	7.010	11 232111	10f. Zip Code		10g.	Citizen of What	Country?
	h with	O IE	10826 Harford Roa	h		21057		т	J.S.A.	
920	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or items 23c or 28e-f ehow event, it is Madical Exert the remained at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	H	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No-	14. Race - A. Black, W Specify:	merican Indian, hite, etc. Mite
21215-0036	within 72 ho ene. then "natur re w. circil	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing 16b	. Kind of Busine	
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	1 all Heal		Denise C. Caton 20a. Method of Disposition	20b. Plac	e of Dispos	Harrord sition (Name of lettorry ner pilot	Road - G	len Arm, N		21057 or Maryland
JOE L	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ P							
Baltimore,	permit. Pag Department Importent: i eny injury o once.		21. Signature of Funeral Service Licens		22.	. Name and Address	s of Facility ${f E}_{ullet}$		n Funera	l Home, P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ALCOHOLIC C		0515		-		Onset and Death
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	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):					
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90,	cate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a consequer	nce of):					
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<u>α</u>	that the de led by the a detached		Part II. Other significant conditions con	stributing to death but not resulting	ng in the un	derlying cause give	n in Part I.	23e. Did tobaco	o use contribute	to the cause of death?
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Vital Record	sw require s been si	ompleted						24a. Was an		autopsy findings available
Re	The law rate has be page 2 sh	шо						autopsy performed	? death	
ital		3e C	25. Was case referred to medical				26. Place of Death	1 Yes 2 X	Vo 1	212/110
of V	lis din	To B	examiner?	ospital: 1 Inpatient 2 ER	/Outpatient	Othe	-	me 5 Residence	6 ☐Other (Sp	pecify)
			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury Work	at ?	28d. Describe how in	jury occurred	
sio	r Attending er death. rector: After by the fune	cati	Accident investigation 3 Suicide 6 Could not be				es 2 No			
=	Sire	ertification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Street City or Town, St		Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dis completely filled in	ledical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medicel Examin	sicien: To the best of my knowle her: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occurr	and due to the cause ed at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	中語書	Me	29b. Signature and title of certifier			29c. License	number	29d. [Date signed (Mo	nth. Day, Year)
	T W I		Detroute &	C.M. culley. M.D.		n Ba	663		06	15/2005
			30. Name and address of person who co		Ba) (Type, F		663		06	15/2005
1				mpleted cause of death (Item 23	1 09	Print)		ON. MARY		

			1 - For State Registrer	State of N	/larylar		artmen rtificat			and M		giene	005	20	150
	Physici	an	Decedent's Name (First, Middle, Las.								2. Date of Dea	ith		3. Time	
	/Medi		Mary Louis								MUNE	1 E,	200	7:58	Ам
	Examir	ner	4a. Facility Name (If not institution, give Saint Joseph M	ledical	Cent					WSOT			County of Dea Balt	imore	
	Funeral Director		5. Social Security Number 6. Se 215-32-3770 15 Usual Residence of Decedent	X 7. A □M 2∭ F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birtl July 2	Year)	9. Bit	thplace (State ountry MD	or Foreign
Jand	*		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside (Dity Limits
Ma	55	ţor	MD Carro	11		Syke	svill	e						1 ☐ Yes	s 2∑No
h with the	3a or 28	Funeral Director	10e. Street and Number 143 Liberty Road		-		10f. Zip	Code 2178	4			10g. Citiz	en of What C	ountry?	
5-0036 72 hours after death with the Maryland	if of Health and Mental Hygiens. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event. Its Medical Evantrat must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	?] No		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whi	te, etc.	
Maryland 21215-0036	"natura	Completed t	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	kind of wor	rk done a	urina most	of workin	ng		d of Business		
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Ma Mass	ulth an 27 is r trau		Mr. Marvin Clarke)	143 L					sville,			Zip Code)	
Baltimore,	of Hear	ď	20a. Method of Disposition		20b. F	Place of Disport		-			-		ation - City or	Town, State	
im Page	ant: If		1 XBurial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)			sley Ch				6/16	/2005	Syk	esvill	e, MD	
Bail permit.	Department of P Important: If ite any injury or ot		21. Signature of Funeral Service Licens	wicht		H S	AIGHI ykesv	fun ille	ERAL	HOME 2178	& CHAF 4 (410)	EL, -795	PA (Bo 5-1400	x 195)	
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Tot	withi To tl	M	29b. Signature and title of certifier		\supset	MO	29c.	License	number		29		signed (Month		
	a		Kickad	_with,	CUL		D	3188	26			(e-	-12-0	55	
1			30. Name and address of person who co	mpleted cause of	death (Item	n 23a) (Type, P	Print)								
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			State of Ma	aryland / Dep			•		•		
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Physic /Med		Doris McCaffre	y Clancy				June	11,	2005	8:15 A	A
Exami	ner	4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Deat	th		County of Death		
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p v		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L							
Manyla 1 sho	ō	MD Howard	Ē	Ellicott						0d. Inside City Limit: 1 ☐ Yes 2 🕅 No	
r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Cour	ntry?	_
ING 21215-0036 be filed within 72 hours after death with the Maryland hat Hygiene. d other than "naturat", or Items 23a or 28a-1 show event, the Modical Examinar must be notified at	aD	5320 Dorsey Hali	l Drive, Ap	ot. 417	210	42		U	SA		
er dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.))-	14. Race - Americ Black, White,		
rs afte	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2X No	Specify:			Specify: Whi		
2 hou	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occup	pation	44	16b. Kir	nd of Business/Inc	dustry	
Athin Je	Completed	(Specify only highest gi	College (1-4or 5	+)	kind of work done DO NOT use retire	d)	rking				
filed v Hygie ther t	S	12 17. Father's Name (First, Middle, Las	t)	Hor	nemaker	18 Mother's Nar	me (First, Middle		Own Home		_
\$ \$ \$ \$ \$ \$	To Be	Christopher McC				Ethel We		, walden	Surrame)		
ore, Maryland 21215-0036 is 1 and 2 should be filed within 72 hours af if Health and Mental Hygiene. item 271s marked other than "naturat", or other traumatic event, the Medical Exert	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Ru	ural Route Numb	er, City or	Town, State, Zip	^{Code)} 21042	_
2 8 E 9		William J. Cland	cy — husban	d 5320	Dorsey H	all Dr.,	Apt. 41	7, E	llicott	City, MD	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any Injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. Place of Disposementery, cre			Date		cation - City or To		
it. Pa artmer artant ortant Injury		 '4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 	*	Arlingtor			5/2005	Ar1:	ington,	Virginia	
B P P P P P P P P P P P P P P P P P P P	10	Mak. A	adoma	W3	Name and Addre Ltzke Fun 555 Twin	eral Home	es, Inc.	ımbi:	a MD 2	1045	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	nplications that caused						2, 110 2.	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Pneumoni							Onset and Death	
/Medical Examiner		resulting in death)		consequence of):							
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ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Sacral D	ecubitus t	llcers						
6U, be executed ician and burial-transit	Exe	resulting in death) Last	Due to (or as a	a consequence of):							
68/60,	dlcal		d.								
7 2	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				2	3d. Date of delive	D/	
death cer death cer e attendir	iclar	in the past 12 months?	1 □ Live birth : 4 □ Pregnant at		□Ectopic pregnanc; □ Other <i>(specify)</i> _	y 		-		Day Year	
ords, P.O requires that the een signed by th hould be detache	Phys	9 🗆 Unknown	9□ Unknown						-		
ires th	by	Part II. Other significent conditions Diabetes M		it not resulting in the u	inderlying cause giv	ren in Part I.				e cause of death? ably 4XJUnknown	
ecords, law requires t as been signe 2 should be	ompleted	Cononary	Vator: Dico	222			24a. Was				
The law ate has b	dwo	Corollary	Artery Dise	ase			autop perfo	osy rmed?	prior to con death?	osy findings available inpletion of cause of	,
	O	25. Was case referred to medical		·		26. Place of Dea	1 Yes	2X No	1 L Yes	2 No	_
<u>-</u> ≥ ≅ ≥	To B	examiner? 1 ☐ Yes 2X No	Hospital:		nt 3□ DOA Oth	ier: 4 Nursing H			Other (Specify)	
on on ding Ph th. After thi funeral	cation:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe				
VISION Attending ar death. ector: Atte	fleat	2 Accident investigation 3 Suicide 6 Could not 1 4 Hemicide determined	De 290 Place of Injur	ry - At home, farm, st		Yes 2 □ No	28f. Location (S	Street and	Number or Rural	Route Number.	_
s after s afte	Certifi	4 Homicide	building, efc	(Specify)			City or Tov	vn, State)		, , , , , , , , , , , , , , , , , , , ,	
Hospit I hour unere	edical (29a. Certifier 1X Certifying P	hysicien: To the best o	f my knowledge, deat	h occurred at the tir	ne, date and place	, and due to the	cause(s)	and manner as sta	ated.	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medi	29b. Signature and title of certifier	and manner stat	led.	29c. Licens						
Veri To	-	BALLI (Dun A	Henriche	9, D425				signed (Month, E 11, 200		
27		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type.	/			- 0110			_
20		Parmjit Singh Au	ijla, MD 5	632 Annapo		Ste. 13,	Bladens	sburg	, MD 20	710	
St	ate	31. Date filed (Month, Day, Year)	005 32 Registra	r's Signature	called						

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DORIS CLADUCY.

			1 - For State Registrer	State of Marylan		artment of tificate of		Mental Hy	/giene) 5 /	20155
ı	Physic	ian	1. Decedent's Name (First, Middle, Last)		C 1		+	2. Date of D Month	Day	Year	3. Time of Death
	/Medi		JOHNNI		C 77 L	UER		すいんご		2005	8:20 AM
	Exami	ner	4a. Facility Name (If not institution, give s Heartlands Assiste				or Location of Dea	th	4c. County		
	Funeral		5. Social Security Number 6. Sex		last birthday)		tt City	S. 8 Date of Bi		vard	no /Stata as Fasaira
	Director			M 2⊠F 92	Yrs.	Months Days		. (Month, D	ay, Year) 6, 1912		ce (State or Foreign
	р		Usual Residence of Decedent					1100. 2	0, 1012	_MISSI	ssippi
	anyla shov	7	10a. State 10b. County MD Howard		y, Town or Lo licott					10d.	I. Inside City Limits
	the M	Director									1 ☐ Yes 2 No
	with	급	10e. Street and Number 3004 N. Ridge Roa	0.12 +a4 5e		10f. Zip Code	21042		10g. Citizen of		1?
	72 hours after death with the Maryland naturel', or items 23e or 28e-1 show disal Exandrat must be notified at	Funeral	<u> </u>	12. Was Decedent Ever in U.	S 13 V	Vas Decedent of	21043	Specify Ven or N	USA		tadian
(0	r iter	FILE	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	II.	Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Bla	ce - American ck, White, etc	
03	rei', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 21 No	Specify:		Specify	^{y:} Black	:
21215-0036	d within 72 hours after death with the Marylan Jene. Ir then "naturel", or items 23e or 28e-1 show The Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	ent's Usual Occu	pation during most of wo	orkina	16b. Kind of B	usiness/Indus	stry
121	within ene. then "	шp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	ed)	9			
72	e filed within al Hygiene. other then		12 17. Father's Name (First, Middle, Last)	6		eacher	10 Markada Ma	(Final Adiabat	Texas Pu		Schools
ano	d be antal	Be c	Zach Howard				Celeste		, Maiden Suman	10)	
Maryland	2 should be and Menta is marked eumatic ev	ြ	19a. Informant's Name/Relationship (Typ	pe. Print)	19h Mailin	n Address (Stree	t and Number or R		er City or Town	State 7in Co	a de l
	and 2 ealth a m 27 is		Maurine McKinley -	*			Point Rd			21044	
Jre,	T to to		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of latory or other pla	rollic Ita	Date	20c. Location -		
E	Pages nent of I ent: if its ury or o		1 ☐ Burial 2 X Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)				rem. 6/	15/2005	Laurel	. MD	
Baltimore,	permit. Pages Department of Importent: If i any injury or ance.		21. Signature of Funeral Service License	90	22.	Name and Addr	ess of Facility			.,	
_	8959			man	155	bb Twin	eral Home Knolls Ro	ad Col	umbia M	4D 210	045
	Physician /Medical Examiner	Examiner	23a. Part1. Enter ne disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ESTIV		FANt		(4 RE	Int	oproximate terval Between nset and Death
P.O. Box 68760, 7	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown	Due to (or as a consequence of pregnar 1	ncy death 3 🗆	Ectopic pregnanc Other (specify)	у		23d. Dat Mor	e of delivery nth Day	y Year
σ.	res that t igned by be detac		Part II. Dther significant conditions cont	tributing to death but not resu	Iting in the un	deriving cause on	ven in Part I.	23e. Did t	obacco use contr	ribute to the c	ause of death?
rds,	quires n sign uld be	9	Hypothy R			, ,					y 4 Unknown
O O	sw require s been sig	olete	ANEMIA					24a. Was	an 24h V	Vere autoney	findings available
Division of Vital Record	The lav	Completed	OEMENT	ıń				autop perfo	rmed? d	rior to comple leath?	etion of cause of
<u>i</u>	icien: Th certificate ector, pag	Вес	25. Was case referred to medical examiner?	118			26. Place of Dea	1 ☐ Yes ith (Check only o	_	☐Yes 2☐	11/0
> >	sir dilb	10	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 E	ER/Outpatient	3□ DOA Ott	ner: 4 Nursing H	ome 5 Resid	dence 6 Othe	or (Specify)	
Ē	ing P	on:	27. Menner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe h	now injury occurre	эd	
<u>s</u>	Itend Jeath Tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
\leq	tel or Attending Pl s after death. el Director: After th ed in by the funeral	ertification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree)	et, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rural Ro	oute Number,
	spitei ours a nerei filled	O	29a. Certifier 1 Certifying Physi	cien: To the best of my know	ulodaa daath						
	e Hos 24 h e Fur	edical	(Check only 2 Medicel Exeminations)	cien: To the best of my know er: On the basis of examinati and manner stated.	on and/or inve	stigation, in my o	me, date and place ppinion, death occu	, and due to the c rred at the time,	cause(s) and mar date and place, a	ner as stated nd due to the	d. cause(s)
	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	(Month, Day.	Year)
			I Jan & S	Ech Vs		p 2	5210		74 p	·6 /12	3/2005
	1.		30. Name an odress of person who com	npleted cause of death (Item	23а) (Туре, Р	rint)					2 4446
	V		JERM S	TOGES, Upp	_	167000	CHAMPR.	Di.	COC unp	3.0 . 1	MP
ii,	Sta Registra		31. Date filed (Month, Day, Yestin 1	732 Fegistra Signatu	Tre A	Spare					2 4 6 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 11:11A **Physician** 2005 June 14, **Eleanor** Darling Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 ☐ F Feb. Virginia 1.1918 87 578-01-6774 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "naturel", or items 23a or 28a-1 shov other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√☐ No Rockville Montgomery Maryland Funerai Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 10401 Grosvenor Place #13022 20852 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ¾☐ No Specify: Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit Pages t and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any Injury or other treumatic event. If a Mental Informatic event. College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie C. Evans Rowland E. Darling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20852 10401 Grosvenor Place # 514 Rockville, Maryland June A. Darling (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 20. 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Cedar Hill Cemetery 2005 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc. 1100153 6633 Old AlexandriaFerryRoad Clinton, MD 20735 CC 1 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE Immediate Cause (Final CONGESTIVE HEART **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** EMPHYSEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes No 1 Yes ivision of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check on one Mary EDArling Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of De th 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05 Alparalumon M.D. D-27660 30. Name and apdress of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD20852 11119 ROCKWILLE PIKE, M.D. GOSWAMI ALPAN'A 32. Registrar's Signature 31. Date filed (Month, Day, Year) House It Species Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bathmore City Hospital Baltimore Mercy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, 6. Sex 12 M 2 F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MARYIAND Director 2005 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County or itema 23a or 28a-f show avent, the Mudicul Examinar must be notified at 1 MYes 2 □ No BAltiMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MORE 51 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Importent: If itsm 27 is marked other than "natural", or item any injury or other traumatic. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BIACH Specify: þ 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be LINKNOWN 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Addrass (Street and Number Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of cemetery, crematory or other place) 6:1 MORE BAlte 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 6/2/2005 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on , ich line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease of Lipury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Day Year 5 Cher (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy performed 1 🗌 Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X npatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Kapli

State Registrar mpleted cause of death (Item 23a) (Type, Print)

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 14 P^{M} Patricia Patterson Duffy 6:18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Morningside House of Laurel Laurel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 💢 F Director 264-72-3158 Jan. 23, 1918 Pennsylvania 87 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar minatice contribed at Yes 2 No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 7700 Cherry Lane USA Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: If Yes, Give Year or Dates: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public Elementary/Secondary (0-12) College (1-4or 5+) Nurse/Midwife 12th 6 Health Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simon T. Patterson Edith Flinn permit. Pages 1 and 2 sh Department of Health and Important: It Itam 27 is m any injury or othar traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Duffy/Son 1313 Washington Street, Boston, MA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 24 Cremation 3 Removal from State West Arundel Crem. 6/15/2005 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liven Donaldson Funeral Home, P.A. 22. Name and Address of Facility January 100160 313 Talbott Avenue, Laurel, MD une! 282 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Week Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): **Examiner** 1 week Pneumonia-Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit 10 years Chronic obstructive lung disease attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical đ. as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia of Alzheimer's Type 2 No 3 Probably 4 Unknown 1XXY es Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autonsy perform certificate 2 🔯 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Livin Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No Certification: To this haral Diractor: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural death, 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide To the Hospital o within 24 hours aff To the Funaral Di 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number June 15, 2005 D13671 address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive, Suite 102, Laurel, MD 20707 M.D. B.G. Manejwala, 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 1 2005 Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental 1- State Unpend Item 23a, pt. II, 27, 28a-f, per me G844, 6-28-05 tas Centificate of Death	Hygiene, north on the
	Reg. No. 20159 of Death 3. Time of Death
Physician Michael James Dickerson.	th Day Year
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
UPPER CHESAPEAKE MEDICAL CENTER BELAIR 5. Social Security Number unk 6. Sax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	HARFORD
Funeral Director 5. Social Security Number 4115. Sax 7. Age (In yrs. last birmday) II Under 1 Year II Under 24 Hrs. 8. Date (Mon Months) Days Hours Min. (Months) Days Hours Min.	of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) MARY(ADV)
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location	1 □ Yes 2 No
the the the the the the the the the the	10g. Citizen of What Country?
The second of the specific of	USA 11 Barr Amarican Indian
To a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City 10	or No- ltc.) 14. Race - American Indian, Black, White, etc. Specify:
Pool of the first	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Too. Island of Business/Industry
TO DE A SE SE SE SE SE SE SE SE SE SE SE SE SE	Dept. of Corrections
During the state of the state o	Riddle, Malden Sumame)
Total Maining Addiess (Street and Number of Auta Anoble)	Number, City or Town, State, Zip Code)
S CROS	Beldir MD 21015.
	20c. Location - City or Town, State
= - E E E E E E E E E E E E E E E E E E	HILL, MD 21650.
m & & E & & Dunbelly U. SWICKY EVANS FUNEROR CHAPEL-	BELAIR BNEW PORT DR.
23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or hear failure. List only one cause on each line.	tory arrest, Approximate Interval Between Onset and Death
Immediate Cause (F) of disease or condition resulting in death) A Coclusive Pulmonary Thromboembolism Due to (or as a consequence of):	Onsot and Death
Examiner	
if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Undarying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
The past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify)	
Use the property of the past 12 months? If FEMALE: 23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
O of the first of	
	Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown
Back Injuries; Rheumatoid Arthritis; Chronic Osteomyolitis; Diabetes Mellitus	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∭ Unknown Was an 24b. Were autopsy findings available
a se se se se se se se se se se se se se	autopsy prior to completion of cause of death?
25. Was case referred to medical examiner?	only one)
Hospital: 1 Inpatient 2X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 27. Manner of Death 28a. Date of Injury 11 28b. Time of 11 28c. Injury at 28d. Desc	Residence 6 Other (Specify)
28d. Description of the property of the proper	ect Fell From Wheelchair
3 Suicide 6 Could not be determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ion (Street and Number of Rural Route Number of Paral Route Number of Trcle
Scene Scene Bel A 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to	Air, Md
The part of the pa	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
	29d. Date signed (Month, Day, Year)
OCME	JUNE 15, 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Balt. State 31. Date filed (Month, Day, Year) 32. egistrar's Signature Registrar 33. Date filed (Month, Day, Year) 34. egistrar's Signature	imore, Marvland 21201
State 31. Date filed (Month, Day, Year) 32. egistrar's Signature	, , , , , , , , , , , , , , , , , , , ,

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	Physici	ian	1. Decedent's Name (First, Middle, Las	(it)				Date of Deat Month	h Day Yeer	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give	street and number)		4h City Town	or Location of Death	6	4c. County of Deat	
	Examir	ner	Family Care In	A . s 1	dlivina	4.4	riotsvil	10	Howard	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birtho	ay) If Under 1 Year Months Days	tf Under 24 Hrs.	8. Date of Birth Month, Day, Oct 13,	Year) 9. Birt	hptace (State or Foreign
	Director		217-24-0454 Usual Residence of Decedent	□M 2 TXF	76 Yrs			Oct 13,	1928	MD
	yland Now		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Mar	ctor	MD Howard		Marrio	ttsville				1 Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Code	0.1	1	0g. Citizen of What Co	ountry?
	eath v	eral	12105 Old Freder	12. Was Decedent 8	ever in U.S.	211		acify Vas or No-	USA 14. Race - Ame	nican Indian
9	after d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📆 N	lo	3. Was Decedent of I If Yes, specify Cub		Rican, etc.)	Black, Whit	e, etc.
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show the Madical Examanation and the profilled at	Completed by Funeral Director	3 X Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates:		1 □ Yes 2 😾 No			Specify: W	nite
15-(n 72 h "natu	iete	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of work	ing	16b. Kind of Business/	Industry
212	l withi	omp	Elementary/Secondary (0-12)	College (1-4or 5	* /	aborer			Cleaning	
	be filed ita! Hygid of other event, III	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M		
yla	ould be Mental narked o	2	George W. Ber				Mary H			
Maryland	d 2 sho th and 7 Is mu trauma		19a. Informant's Name/Relationship (7 Mr. Thomas Bensin						City or Town, State, 2 Ottsville,	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or other traumatic event. Its Mulical Exams natural be notified at injury or other traumatic event. Its Mulical Exams natural be notified at 8.	L	20a. Method of Disposition			sposition (Name of crematory or other pla		-	20c. Location - City or	
E O	Pages nent of int: If it		1 ☐ Burial 2 XI Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State		nty_Crematory or otner pia		/2005	Sykesville	e, MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licen	500 1 / 11 /						·
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68 7	entifica ling ph e as th		IF FEMALE:							
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0	that the death ed by the atter detached for	Physician/Med	1 ☐ Yes 2 M No 9 ☐ Unknown	9□Unknown	une or death	5 🗆 Other (specify) _				
S, P	res that igned b	by Pi	Part II. Other significant conditions of	ontributing to death bu	it not resulting in th	e underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w require been sign	ted	Emphysema					1 🗆 Ye	s 2□No 3□Pro	obably 4 Unknown
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	ng fter ine		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injur		ry at rk?	28d. Describe ho	w injury occurred	Civing
Division	l or Attending after death. Director: After in by the fune.	icat	2 Accident investigation 3 Suicide 6 Could not be		Int . At home form	M 1street, factory, office	Yes 2 No	28f Location /Str	eet and Number or Ru	and Pourte Alumbia
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge, de	eath occurred at the tr	me, date and place,	and due to the ca	use(s) and manner as ite and place, and due	stated.
	the H the F the F	Medical	One)	and manner sta	ted.					
)	Je Sign		29b. Signature and title of certifier			29c. Licens		25	6/15/2	
	~		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tvi		1785		0/10/2	~~
_	\		115 Roesler	Road (Flen Bu	rnie, MD	21060)		
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40.0	1	1. Decedent's Name (First, Mid	ddle, Last)	F1/K1	1,107	rth.				2. Date o	Death Da	ay Year	-3.7imb of Death - 18:25 p
/Medical Examiner		a. Facility Name (If not institut	tion, give :	1.1	-/-/	0. 1.	4b. C	City, Town, o	r Location of D		4	c. County of De	
		CheSter Ki 5. Social Security Number	6. Sex	HOSP		Cente In yrs. last birt	R C	hder 1 Year	TC+00V	Irs. 8. Date o	Pieth	Kent	irthplace (State or Foreig
Funeral Director		216-44-8204 Usual Residence of Decedent	*	M 2□F		•	Yrs. Mont			Decem	ber 8	,1944 E	aston, MD
or 28a-f show a notified at		10a. State 10b. Coun	nty		,	Oc. City, Town							10d. Inside City Limit
tor 28a-f sl	20	10e. Street and Number					10f.	. Zip Code			10g. C	itizen of What (Country?
ust b	<u>a</u>	201 Sassafras		.				21635				ited St	
	2	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 图 Divorce	Married	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gir Year or D	orces? 2 T No ve	er in U.S.		ecedent of H specify Cubi es 対かNo	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes o lerto Rican, etc.	No-	Black, Wh	nerican Indian, nite, etc. Vhite
t. the Medical i	para	15. Deced (Specify only high	dent's Educ	cation (e completed)		16a.	Decedent's L	Usual Occup f work done	ation during most of	working	16b. I	Kind of Busines	s/Industry
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	2	Wellington				101	h4 22 - 14	10:		M. Blun			
any injury or other treumatic event, the Magnes. To Re Commo		19a. Informant's Name/Relatio Marla Ellswor			ter		_			Rural Route Nu Impton,			Unk.
or othe	1	20a. Method of Disposition 1 □ Burial 2 □ Cremation	on 3□R	Removal from	State	20b. Place of cemeter	Disposition ((Name of or other plac	сө)	Date	20c. L	Location - City of	
ulury	-	* 4 Donation 5 ☐ Other 21. Signature of Funeral Service	(Specify)			Howard	_			y 19,20			
any ir	- 1	21. Signature of Tierar Service	Co prodinge				ZZ. Naiiit	e and Addie	ss of Facility	Nustin R	oyste	er Funer	al Home
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			1 - For State Registrer	State of M	aryland / [Depa <i>Cer</i>	artmen tificate	t of H	ealth a Death	ind M	ental Hy	giene Reg. No.	. 000	201	63
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last,</i> Ruth Frothingha								2. Date of De June	aath 11 Day	2005	3. Time of D 5:30a	eath M
له	Examir		4a. Facility Name (If not institution, give Fairhaven Health					Town, or esvil	Location o	f Death			County of Dea	ath	
	Funeral Director		5. Social Security Number 6. Sec. 216–44–3938	7. Ag	e (In yrs. last bir 5	thday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da)ct 19	rth ay, Year) 1909	9. Bi Md	rthplace (State or I	Foreign
	tryland show		Usual Residence of Decedent 10a. State 10b. County Md Carroll		10c. City, Town									10d. Inside City	
	th the Ma or 28a-f s e netifies	Director	10e. Street and Number		Byresv		10f. Zip						zen of What C	1 Yes 2	. No
	death wi	Funeral L	7200 Third Avei	1UE 12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Deced		panic Orig	in? (Spec	cify Yes or No	USA 	14. Race - Am		
7036	ours after rral', or its	Þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MYes 2 ☐ I If Yes, Give Year or Dates:			l □ Yes 2		Specify:	, i dello F	ticari, etc.)		Black, Whi Specify: Wh		
9500-61717	be filed within 72 hours after death with the Maryland thygiene. Hygiene. do ther than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5		(Give	lent's Usua kind of wor DO NOT us siste:	k done di e retired)	uring most	of workin	g		of Business		
0	filed Hygi other	Be	17. Father's Name (First, Middle, Last) James Robert Frotl						18. Mother		(First, Middle,	, Maiden			
Mary	d 2 shoul th and Me 7 Is mark traumati	2	19a. Informant's Name/Relationship (Ty Louis Weinkam Sr.				-						Town, State, 21228	Zip Code)	i:
nore,	ages 1 and of Healing 1: If item 2	1	20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ F		20b. Place of	Dispos y, crem	sition (Nam	e of her place	,	Da	ite	20c. Lo	cation · City or		
Daltimo	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens Page 1000 1		AII CC	22	. Name and	Address	of Facility	Haig		nera1	Home	& Chapel	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	cations that caused te cause on each lie	ne.	not ente	or the mode	of dying		ardiac or			1704	Approximate Interval Betwe Onset and Dea	en ath
	/Medical Examiner		disease or condition resulting in death)		a consequence	-	, 41	Chric	7 1 (0	-					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. En any Learly in g	Due to (or as	a consequence of	of):									
,0070	incate be executed physician and is the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as	a consequence o	of):								!	
00 40	death centificate attending phy d for use as the	/Medic	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome	of pregnancy								3d. Date of de	livon	
	the death by the atterached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death time of death		Ectopic pre Other (spe						Month	Day Yea	ır
L (SD)	iaw requires mat the death as been signed by the atte 2 should be detached for	ρ	Part II. Other significant conditions cor	tributing to death b	ut not resulting in	the un	derlying ca	use giver	n in Part I.		23e. Did to	1	<i>_</i>	the cause of deal	- 1
ו שבנים	uith nospital or Attenuing ripsicals. The taw requires that the death certific within 24 hours after death. To the Furbaral Directors After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed								_	24a. Was autor perfo 1 Yes		prior to death?	utopsy findings ava completion of caus	tilable se of
V 15	ysician. is certific director.	To Be (25. Was case referred to medical examiner? 1 □ Yes 2 No H	ospital:	nt 2□ER/Out	tpatient	3 DO	Othor	- 4		Check only o	ne)	□Other (Spe		
	To the hospital or demonstrating registration in the law within 24 hours after death. To the Eurharal Director, After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		ime of ijury	28 M	c. Injury a Work? 1 \(\text{Ye}	at / es 2 □ N		ld. Describe t	now injury	occurred		
	ris after de ral Direct	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	c. (Specify)						City or Tow	vn, State)		ural Route Number	:
	ine nosp in 24 hou the Fune ipletely fil	ledical	one)	icien: To the best of er: On the basis of and manner sta	examination and	, death ∜or inv	estigation, i	n my opii	nion, death	place, an occurred	d due to the d d at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
ŀ		Σ	29b. Signature and fittle of centrier	Sute +	.6.1		1	License				29d. Date	signed (Monti		
	0		30. Name and address of person who co	21 511	orchurco	,	MO	217	34						
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 7 200	320 Registra	ar's Signature	he	the same								

Graham, Helen 4/11/105 1321

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	Dharia		1. Decedent's Nam	ne (First, Middle, Las						2. Date Mont	Reg. N		3. Time of Death
	Physic /Medi		HEL		GRA		<u> </u>			JUN	E 1	1 200	05 1321 M
1	Exami	ner	,	of not institution, give ban Hospit		·)		4b. City, Town, Bethe		Death	4	onty of De Montgo:	
	Funeral Director		5. Social Security 1 217-32			ge (In yrs. 93	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date (Mont) 09-(of Birth h, Day, Yea)8-191	9. 8 1 N	Birthplace (State or Foreign Country) Iew York
	and aw		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Many a-f sho	to	MD	Montgo	omery	Si	lver S	Spring					1 ☐ Yes 2 🔼 No
	h with the 23a or 284 at be rot	ai Direc	10e. Street and Nu 120 Wo	mber odridge Av	ve			10f. Zip Code	20901		_	Citizen of What (Country?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Mari	ried 2 Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		n? (Specify Yes Puerto Rican, et	or No-	Black, Wh	merican Indian, nite, etc. White
5-0	72 ho natur	eted	(Spe	15. Decedent's Educify only highest grad	ucation de completed)		(Give	dent's Usual Occu kind of work done	during most o	of working	16b.	Kind of Busines	ss/Industry
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E O	Page nent o ant: If ary or			©cremation 3 □I 5 □ Other (Specify,				natory or other pla ke Crema		6-15-200	5 B	eltsvil	le MD
Baltimore,	permit. Departr Importa any inj		21. Signature of Fi	peral Service Licens		00382		Name and Addr Rapp Fun		Cremati	on Se	rvice	
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.O. Box	The law requires that the death certificate be the has been signed by the attending physic page 2 should be detached for use as the beather that the state of the	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3□	Ectopic pregnanc Other (specify)	у		-	23d. Date of do	elivery Day Year
rds, P	quires tha	by	Part II. Other signi	ficant conditions co	ntributing to death t	out not resu	ulting in the u	nderlying cause gr	ven in Part I.		Did tobacco 1 ☐ Yes 2	_	to the cause of death? Probably 4 Onknown
Vital Records,	ilcian: The law requir certificate has been s rector, page 2 should	e Completed	25. Was case refer	red to medical					OC Disease	1 U Y		prior to death?	autopsy findings available completion of cause of as 2 \(\text{No} \)
Ž	ysician: nis certific director,	To B	examiner? 1 🗌 Yes 2 🔀	/	Hospital: 1 1 Inpati	ent 2 🗆 I	ER/Outpatien	t 3 DOA		Death (Check of Death (Check o		6 □Other (Sp.	ecify)
lon of	Attending Phy death. ctor: After thi y the funeral o		27. Manner of Deat 1 Natural 2 Accident	h 5 Pending investigation	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Desc		ury occurred	
Division	saior Atte satter des al Directo ed in by th	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In building, et	jury - At ho tc. (Specify	me, farm, str	eet, factory, office		28f. Locati City o	on (Street a r Town, Stai	nd Number or F te)	Rural Route Number,
	or the Hospital or Attending Physician: within 24 hours after death as a strength or the Funeral Director. To the Funeral Director. I completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)	Certifying Phy Medical Exami	sicien: To the best iner: On the basis of and manner st	ot examinat	wledge, death tion and/or inv	occurred at the tivestigation, in my	me, date and popinion, death	place, and due to occurred at the t	the cause(s me, date ar	s) and manner and place, and du	as stated. ue to the cause(s)
)	To the To the comp	W	29b. Signature and	title of certifier	no			29c. Licens			29d. D.	ate signed (Mon	2005
	10		30. Name and addr	ess of person who co	mpleted cause of c	death (Item	23a) (Type,	Print) nal	Ln. H	409 1	Rocki	rlle M	2005 020852
	Sta Registr		31. Date filed (Mon	th, Day, Year)	05 32 degistr	rar's Signat	tyre	ale			-		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13, 2005 Month **Physician** Frances Grossnickel Louise 2:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 26, 1925 **Funeral** 6. Sex 9. Birthplace (State or Foreign Days 1 □ M 2 🛛 F 79 212-20-8235 Yrs. Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Midlical Examiner must be notified at Director Maryland Baltimore 1 Yes 2 No Middlesex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Ave., Unit #313 21221 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2X No White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Gunther Lucille Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If item 27 is any injury or othar trau once. Mrs. Doris Hughes (daughter) 1015 Vale Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 6/18/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of uneral Service Licens 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADULT RESPIRATORY DISTRESS SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed c. PNEUMONIA resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 ☐ No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No CLOSTRIDIUM DIFFICILE COLITIS 24a. Was an performed? Yes 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. D te of Injury (Month, Day funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 1 24 hours after deatle Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) LLIV -nott

Registrar

32. Registrar's Signature ORIGINAL

D 31826

7601 OSLER DRIVE TOWSON, MARYLAND 21204

6-13-05

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W. D.,

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XN 1 7 2005

RICHARD LINTHICUM.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Maryland		artment of tificate of		and Me		giene Reg. No.	005	20166
	Physic	ian	Decedent's Name (First, Middle, Last)	-	-				. Date of Dea		OF Year	3. Time of Death
	/Medi	cal	Charles Ea 4a. Facility Name (If not institution, give str		Gar	dner			une 12			5:28p м
	Examir	ner_	Southern Maryland			4b. City, Town,	or Location of .nton	of Death			ounty of Death nce Geor	rge's
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Yea	r If Under		. Date of Birt	h	9. Birtho	ace (State or Foreign
	Director			^{1 2□ F} 70	Yrs.	Months Days	s Hours	Min.	April	11,19	935 West	Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, 7	Town or Lo	cation					10	Od. Inside City Limits
	a-fsh	tor	Maryland Prince Geo	rge's	В:	randywin	ie					1 ☐ Yes 2√☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code				10g. Citize	n of What Coun	try?
	s 23a	erai	5311 Accokeek Ro			20613				.,	U.S.A.	
"	fter de r Item	Funerai	11. Marital Status 12 1 □ Never Married 2 → Married	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No	13. V	Vas Decedent of Yes, specify Cu	Hispanic Original Mexican	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)	14	Race - America Black, White, e	
036	ours a		3 Widowed 4 Divorced	1 ☐ Yes 2XXVo If Yes, Give Year or Dates:	1	☐ Yes AMN	Specify:			S	рөс <i>ify:</i> Whi	te
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ylar	12 should be filed within and Mental Hygiene. Tis marked other than raumatic event, Ibe M	To B	Mitchell Gard	ner				Dorot	hy	Terry	y	
Maryland 21215-0036	8 8 7		19a. Informant's Name/Relationship (Type	1.		g Address (Stree						Code)
	ges 1 and 2 t of Health If item 27 i or other tra		Barbara Gardner (Wi			Accokee sition (Name of patory or other pla					tion - City or Tox	am State
O E	0 0		1 ☑Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)			natory or other pla n Nation		une ^D i			Land, Ma	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Functal Service Licensee			. Name and Addr						
m	99 = 9		MA WHah	1900153	dria .	Ferry	Road	Clinton	, MD20735			
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death.	Do not ente	er the mode of dy	ing, such as	cardiac or re	espiratory arr	rest,	45.	Approximate Interval Between Onset and Death
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7	p it	iner	Sequentially list conditions, ii any, leauning to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice oi):							
V	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	ice of):							
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical E	d									
9	rtificate ng phys as the	Medi	IF FEMALE:							1		
Вох	leath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal de	ath 3	Ectopic pregnanc	су			23d	d. Date of deliver Month (y Day Year
	e = e .	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	h 5□	Other (specify) _					inontal E	Jay Toal
σ.	res that the igned by be detact	by Ph	Part II. Other significant conditions contri	buting to death but not resulting	ng in the un	derlying cause g	ven in Part I.		23e. Did to	bacco use	contribute to the	cause of death?
ords	w requires that been signed b should be deta								1 🗹 Y	es 2□N	No 3 ☐ Proba	bły 4 □Unknown
Records	aw as b	Completed							24a. Was a		24b. Were autop	sy findings available pletion of cause of
_	Th ate pag								perfori 1 ☐ Yes	ned? 2 No	death? 1 ☐ Yes 2	□ No
Vital		o Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 ☐ ER	/Outpatient	3□ DOA Ot	h		heck only on		7011 (0.11)	
		-			b. Time of Injury	28c. Inju			. Describe ho		Other (Specify)	
sioi	Attending r death. sctor: After by the fune	catic	2 Accident investigation			M 1	Yes 2 N	lo				
á	I or Attendater death	Certification:	4 Homicide determined	 Place of Injury - At home building, etc. (Specify) 	, farm, stre	et, factory, office		28f.	Location (St City or Town	reet and N n, State)	lumber or Rural	Route Number,
_	ospita hours ineral y filled		29a. Certifier 1 Certifying Physic	an: To the best of my knowled	dge, death	occurred at the fi	ime, date and	place, and	due to the ca	ause(s) and	d manner as sta	ted.
	To the He within 24 To the Fu	ledical	one)	On the basis of examination and manner stated.	and/or inve	estigation, in my	opinion, deatl	n occurred a	at the time, d	ate and pla	ace, and due to t	he cause(s)
	with To	Σ	29b. Signature and title of certifiles	N		29c. Licen	se number	7	2	9d. Date si	igned (Month, D.	ay, Year)
			30 Name and address of person who comp	Very cause of death (in the	(a) (T:-	UI.	105	2		4/	12/(12
	15	ŀ	30 Name and address of derson who comp	leted cause of death (Item 23	150	Levr	ratts	RA	4201	AC	linta	My 20735
	Sta Registr		31. Date filed (Month, Day, Year) 7 2005	32. Segistrar's Signature		sel.		,			111111111111111111111111111111111111111	, ,

			for State	State of Ma					and Me	ental Hyg	iene		
			Registrar 1. Decedent's Name (First, Middle, Last	1		Certificate	OT D	eatn			g. Nor	05	20167
	Physic	an	Maxine J.	_ ·					2	Date of Deat Month	n Day	Year	3: Time of Death
	/Medi		4a. Facility Name (If not institution, give		ies	41. Ch. T				06_	15	2005	5:40 PM
	Examir	ıer		2 'al a	0	4b. City, T	own, or Lo	ocation of	f Death		1	y of Death	
	F		5. Social Security Number 6. Sec	1000	e (In yrs. last birth	iday) If Under 1	YALL	ESU If Under 2	111e	Date of Birth		RRC	
г	Funeral Director			14 20 5				Hours	Min.	B. Date of Birth (Month, Day, Oct 12,	^{Year)} 1930	Coun	lace (State or Foreign try) evada
			Usual Residence of Decedent							12,	1930	11/6	vaua
	show		10a. State 10b. County		10c. City, Town	or Location						11	0d. Inside City Limits
	a-f s	cto	MD Carro	11		Sykesv	ille						1 ☐ Yes 2X☐ No
	ours after death with the Maryla rai', or Itams 23a or 28a-f shov Exacultur cust by nellified at	Director	10e. Street and Number			10f. Zip C	ode			10	g. Citizen of	What Coun	try?
	23a	a	710 Obrecht Road				21	784			US	SA	
	Itams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede If Yes, specif	nt of Hisp	anic Orig	in? (Speci	fy Yes or No-		ce - Americ	
36	or It		1 Never Married 2 Married	1 Yes 2 X	No	1 ☐ Yes 2[Specify:	, , , , , , , , , , , , , , , , , , , ,	ouri, oto.)		ick, White, 6 <i>fy:</i> Whit	
21215-0036		d by	3 XWidowed 4 □ Divorced	Year or Dates:							Speci	· WIII L	.e
5	n 72	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	- (Decedent's Usual Give kind of work	done duri	on ring most	of working	,	6b. Kind of E	Business/Ind	lustry
12	withii ene. than	m d m	Elementary/Secondary (0-12)	College (1-4or 5	i+)	<i>lite. DO NOT</i> use omemaker	гешгеа)				Dame		
d 2	be filed within 72 hatal Hygiene, id othar than "natu evant, Ira Magical	e C	17. Father's Name (First, Middle, Last)		<u>n</u>	omemaker	18	8 Mother	r's Namo /	First, Middle, N		estic	
Maryland		8	Tony Sever							beth Lo			
7	2 should be and Menta Is markad sumatic ev	은	19a. Informant's Name/Relationship (Ty	ne Print)	106	Mailing Address (Stroatona						
≅	od 2 s lith ar 27 is trau		Mrs. Michelle Wil	•									
ē,	s 1 and 2 should f Health and Mer itam 27 Is marks othar traumatic		20a. Method of Disposition	IID (Daug	20b. Place of D	Disposition (Name	of	ind i	Dat		Oc. Location		
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery	crematory or oth	er place)	6				•	
≢	nit. Pa partmen ortant: injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	ae /	ATT CO	unty Cre					Sykesvi		
Ba	permit. Pages. Department of H Important: If its any injury or of		Drian d.	HULL		HAIGHT Sykesvi	FUNE 11e,	RAT.""I MD	HOME 21784	& CHAPE (410)-	L PA 795-14	(Box	195)
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused	the death. Do no								Approximate
	Pnysician		Immediate Cause (Final disease or condition	Cert		1410-6.						1	Interval Between Onset and Death
	/Medical		resulting in death)		a consequence of):						-	6 Ma
	Examiner		Sequentially list conditions										
¥1.	# # #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):							
	nd rrans	Examine	that initiated events										
Ő,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	a consequence of	:							
8760,	ate b hysic the b	dical											
9		Mec	IF FEMALE:										
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	of pregnancy 2 Fetal death	3 ☐Ectopic preg	nancy					te of deliver	,
<u>.</u>	0 0 0	Sic	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (spec	ify)				MC	onth [Day Year
P.O.	that the died by the detached	P.		A-16-A-1-A-1-A-1-A									
	Se US	by	Part II. Other significant conditions con	tributing to death bu	at not resulting in t	ne underlying cau	se given i	n Part I.			_		cause of death?
oro	v require been signature	ted								1 L Yes	2 Mo	3 🔲 Proba	bly 4 □Unknown
Records,	aw as b	Completed								24a. Was an autopsy	24b.	Were autop	sy findings available pletion of cause of
-	Th ate pag	Co								perform 1 ☐ Yes 2	ed?	death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					3. Place o	of Death (C	Check only one)		
of	Physic this cral dir	2	1 163 2 2 1 1 1 1 1		nt 2 ER/Outp		Other:	4 Murs	sing Home	5 🗌 Residen	ce 6 □Oth	er (Specify)	
	ing After une	lon	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tin (Year) Inju	ıry	Injury at Work?			I. Describe how	injury occur	red	
Si	Attanding or death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be			М		2 🗆 No					
Division	in Sir fe	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm . <i>(Specify)</i>	, street, factory, o	ffice		28f.	Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
	pital purs aral filled		29a. Certifier 1 Certifying Phys	icies. To the best	f to a fine								
	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the basis of and manner stat	examination and/	or investigation, in	my opinio	date and i	occurred	at the time, dat	se(s) and ma e and place,	inner as sta and due to t	ted. he cause(s)
	To the Within To the Comp	Me	29b. Signature and title of certifier			29c. L	icense nu	ımber		290	d. Date signe	d (Month, D.	ay, Year)
)	0		I flored d. 1.	Mon. 1	ness of	/	172	0	100		6//	6/	3/
6	- \		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Ty	rpe, Brint)		_		1 10	./	-	/
7			Robert 6. M	1011	114	BAINT		C 6	anti	- U.	Ne)	3 8343	four, MI
17	Sta	te	31. Date filed (Month, Day, Year) JUN 1 7 2005	82. Registra	r's Signature								
-	Registra	ar	JUN 1 7 2005	Maria	1. Con	solle D							

	CS	,50	For State	State of Marylan	-		of Health a	ınd Mer		giene Reg. No. 2 11 11	E 00100
I	Physici		Registrar Decedent's Name (First, Middle, Last) MILDRED	GALIANO		imouto		2.	Date of Dea Month June	ath Day Y	3. Time of beam 05 10:00 a ^M
	/Medio Examin		4a. Facility Name (If not institution, give				m, or Location of	f Death	0,000	4c. County of N	Death
	Funeral Director		5. Social Security Number 214-03-1701 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y Months Da	ear If Under 2 ays Hours	Min. A	Date of Birth (Month, Day PR .	20,1916	Birthplace (State or Foreign Country) MARYLAND
	Maryland	tor	10a. State 10b. County MD • N/A	10c. City	, Town or Lo	cation IMORE					10d. Inside City Limits 1 X Yes 2 □ No
	ath with the Marylan s 23a or 28e-f show	I Director	10e. Street and Number 405 S. CLINTON	STREET		10f. Zip Co	de 1224			10g. Citizen of Wha	
9036	hours after death with the Maryland tural', or Itams 23a or 28e-f show all Evarult artifulate inclined at	d by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:			of Hispanic Orig Cuban, Mexican	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14. Race - Black, '	American Indian, White, etc. WHITE
21215-0036	within 72 ane. than "na	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. i	dent's Usual O kind of work d DO NOT use re ETARY	one during most	of working		BALTIMO	RE CITY
Maryland		To Be C	17. Father's Name (First, Middle, Last) LLOYD GIFFOR 19a. Informant's Name/Relationship (Ty				PAU	JLINE	KEE	Maiden Surname) ENE r, City or Town, Sta	To Ordel
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumatic QDC8.			STER 20b. P ce HOI	210 lace of Disponentery, crem	KERRIE sition (Name of matory or other ILL CE	E LANE	BALT Date	IMORE	E MARYLA 20c. Location - Cit	ND 21220 y or Town, State ORE, MARYLAND
8760,	cate be executed by sician and characteristics and and and and and and and and and and	dical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	er the mode of		cardiac or re	espiratory arr	rest,	Approximate Interval Between Onset and Death
.O. Box 6	the death certifi y the attending p iched for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregn Other (specif				23d. Date o Month	f delivery Day Year
Δ.	es gu	ру Р	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying caus	e given in Part I.				te to the cause of death? Probably 4 Unknown
al Records,	The law ate has b page 2 si	Completed								sy prio med? dea 2 No 1 □	re autopsy findings available r to completion of cause of th? Yes 2 No
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation 3 Suicide 6 Could not be determined	Alospital: 1 Inpatient 2 28a. Date of Injury (Month, August 1) 28e. Place of Injury - At he building, etc. (Specify)	me, farm, str	28c.	Other: 4 Nui Injury at Work? 1 Yes 2 X	rsing Home 28d No	10) ect	lence 6 ther (low injury occurred	. (4)
	e Hospitel 24 hours a e Funaral I letely filled	edical C		sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death	occurred at the				ause(s) and manne	
)	within 2 To the Complete	Me	29b. Signature and title of certifier	n - Rela) cl_ v		cense number		2	June 14,	
	b		30. Name and address of person who co	mpleted cause of death (Nem	SILAK	Print)	l Penn S	Street	Balt	imore, M	aryland 21201
	Sta Registi		IIIN 1 6 2005	Ross Hogistrar's Signa	Anna	15					

				1-State Amend Item	State of Mars 23a per	ryland/De	partme	nt of F	lealth an ∄éՁኽd l	d Me h b	ntal Hy	giene Reg. No	400	5	20	169
		Dhamiai		1. Decedent's Name (First, Middle, Last)					2	2. Date of De Month	aath Da	y Yea	ar	3. Time	
		Physici /Medio		Pearl Mary Hill						J	une	9	200		9:5	3 рм
		Examir		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, o	r Location of D	eath		4c	. County of D	eath		
				Gilchrist Cente				owso:					altimo	ore		
		Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birtho	Month		If Under 24 Hours	Hrs. 8	1. Date of Bir (Month, Da 1 – 26	th ay, Year)	9. 1	Birthpla Count	ce (State	or Foreign
		Director		200-30-3013	J M 2(A)	96 Yrs	5.			1	1-26	-08	G?	<u> </u>		
		and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location							10	d. Inside (City Limits
7		Aarylan I show	5	MD		Baltim										s 2 No
Ë		the Maryla 28a-f shov	ect	10e. Street and Number		Dartin		ip Code				10a Cit	izen of What	Count		
0.		with	ā	4673 Park Heigh	+ 7770			1215			}	USA		00411	., .	
0		within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show he Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S.			lispanic Origin	? (Speci	fv Yes or No		14. Race - A	merica	n Indian,	
10	"	fler of	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				lispanic Origin an, Mexican, P	uerto Ri	can, etc.)		Black, W			
41	036	urs aft ai', or		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No	Specify:				Specify:B]	Lac	k	
0	5-0036	72 hours "natural",	ted	15. Decedent's Edu	ucation	16a. De	ecedent's Us	ual Occup	ation	working		16b. K	ind of Busine	ss/Indi	ustry	
	215	thin 7	pie	(Specify only highest grade Elementary/Secondary (0-12) 7 th	College (1-4or 5+) (ii	e. DO NOT	use retired	during most of d)	WOIKING						
1	21	ed wi	Completed by			Dom	estic	;					vate			
5	pu	d oth	e	17. Father's Name (First, Middle, Last)					18. Mother's				Sumame)			
2005	yla	Men Men arke	ျှ	Edward Hardwick					Rebec							
0	Maryland 21	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or any injury or other traumatic event, the Medical Examiner must be ODEs.		19a. Informant's Name/Relationship (T)			-		and Number o			-		e, Zip (Code)	
_		and lealth m 27 her tr		Carla Nelson(G	randdaugn				r Rd		to. N				•	
5	Baltimore,	pes 1 of H if its		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State		crematory o	other plac	ce)	Da	.0	20c. L	ocation - City	or I ow	m, State	
une	Ē	Pag ment ant: lury		* 4 ☐ Donation 5 ☐ Other (Specify)		Sacred							dalk,			
3	Salt	epart nport		21. Signature of Funeral Service Licens	ee, 1				ss of Facility		_					
17	_	90 E 9 9		Nanel I.A	unler				ern A				MD 21	1		
1 (23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line	ne death. Do not	enter the m	ode of dyin	ig, such as car	diac or	espiratory a	rrest,		- 1 - 1	Approxima Interval Be	tween
		Physician		Immediate Cause (Final disease or condition	arin	al tai	here								Onset and	
		/Medical		resulting in death)	Due to (or as a	consequence of):										
		Examiner		Sequentially list conditions.	Rhabdo	omyolys	is									
		₽ #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):										
		and trans	me	that initiated events resulting in death) Last		aryngea		shas	ia					-		
	760,	ate be executed hysician and the burial-transit	Ω.	Todaking in doubly East		consequence of):		N								
	0	ate b	dicai		d. Cerebi	covascu	lar)ISE	ase			-		+		
	9 X	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE:	22a Huga autaema of											
8	Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 DEctopic						23d. Date of o Month		y Day	Year
18	o.	t the de by the a tached t	sic	1 Yes 2 No	4□ Pregnant at tii 9□ Unknown	me or death	5 Other (specity)								
The	<u>a</u>	that the		Part II. Dther significant conditions co	ntributing to death but	not resulting in th	e underlying	CALISE CIV	en in Part I		23e. Did t	obacco i	use contribute	to the	cause of	death?
	S,	ires tha signed I I be det	l by					, g					□No 3□			Unknown
	0	w require been sig should b	etec							_						
	Sec.	The law cate has t page 2 s	Completed								24a. Was		24b. Were prior t death	o com	sy findings pletion of	cause of
	<u>E</u>	cate pag									1 Yes	2 X No			□ No	
AR	of Vital Record	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of				L		f 0	
(O.	of	Phys this al dir	To	1 ☐ Yes 2 7 No	1 U Inpatient			DOA	4 INUISII		5 Resid. Describe		6 Other (S	pecify)	nozpi	a
	no	ding F h. After funer	lon	1 Pending 5 □ Pending	28a. Date of Injury (Month, Day	Year) 280. Tilli		28c. Injun Wor	yal k? Yes 2 □ No	20	u. Describe	now injui	y occurred			
	<u> Si</u>	Attending Physician: r death. sctor: After this certific. by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	u - At home form			765 2 100	28	f Location /	Street an	d Number or	Bura!	Boute Nu	mber
	Ξ	or A	rtif	4 Homicide determined	building, etc.		, Street, lacti	ory, onice		20	City or To			nuiaii	HODIO IVUI	IIDei,
		To the Hospital or Attandl within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying Phy	sicien: To the best of	mu knowledge, d	ooth coourse	d at the tim	no data and a	1000 000	d due to the	50		an etai	lad	
-		Hos 24 hc Fun stely	edicai		ner: On the basis of e	xamination and/o										s)
		To the within 2 To the comple	Me	29b. Signature and title of certifier	1	-	2	9c. Licens	e number			29d. Dat	te signed (Mo	nth, Da	ay, Year)	
		⊢ 3 ⊢ ŏ		MULL	1 Land			-	8303				ne 10			
	7			30 Name and address of person uto or	ompleted cause of dea	th (Item 22a) (To	ne Printh					_				
				30. Name and address of person who co	(XS WY)	660(N.C	rente	is st	13.	Som	MO	212	-04	,	
		Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar											
		Registr		JUN 1 7 2005	Blother	is the	de									

			1- State Amend Ite	State of Mar	yland / De	epartmer C844.ca	106 H	ealth a	and M 5dhb	ental Hy	giene Reg. No.	005	20170)
	Physic	ion.	1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath Day	Year	3. Time of Dea	th
	Physic /Medi		ELWOOD DARE HARI	RISON						MAY à	91 =	2005	3 30p.	М
	Exami		4a. Facility Name (If not institution, give	e street and number)	1	4b. City	Town, or	Location	of Death,		4c. (County of Deati	1 (
			North Hrunde	1 Hospita	1	9	len	Du	rni	<u>e</u>		me A	rundel	
-	Funeral		5. Social Security Number 6. S	Sex 7.Age (IXXM 2□ F	In yrs. last birtho Q Q Yrs	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birti	npiace (State or For untry)	reign
	Director		227-18-6260 Usual Residence of Decedent		83 Yrs					12/17/	1921		VA	
	land		10a. State 10b. County	1	Oc. City, Town o	r Location							10d. Inside City Lir	mits
	the Marylar 28e-f show	to	MD ANNE ARI	JNDEL	GLEN BU	RNTE							1 🗋 Yes 2 🔀	No
	ith the	Director	10e. Street and Number				p Code				10g. Citiz	zen of What Co	untry?	
	death with the Maryland ims 23a or 28e-f show ir must be notified at	al D	27 COUNTRY CLUB	DRIVE		2	1060					USA		
Ξ	deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.))- 1	4. Race - Ame		
స్త్రా	ours after dea al', or Itams Examiner m		1 ☐ Never Married 2 🕅 Married	1 X Yes 2 No If Yes, Give	1945-	1 🗆 Yes		Specify:		riicari, etc.)	i			
<u></u>	72 hours after natural', or Ita ileal Exomine	d by	3 Widowed 4 Divorced	Year or Dates:	1946							Specify: WH	ITE	
77.	"nati	Completed	15. Decedent's E (Specify only highest gra		16a. D	ecedent's Usu Give kind of wo fe. DO NOT u	al Occupa	ation during mos	t of worki	ng	16b. Kin	nd of Business/I	ndustry	
25	within ene. than *	ф	Elementary/Secondary (0-12)	College (1-4or 5+)		CHINIS		,			MANI	UFACTUR	TNC	
% 0 0 0 0	fited Hygi httper ant, L	ပိ	17. Father's Name (First, Middle, Last)	1111	OHITHED		18. Mothe	er's Name	(First, Middle			ING	
and 2	d be ental kad c	To Be	JAMES WILSON HAR	RISON						EVANS		Í		
\Z	2 should be filed within 72 hours and Mental Hygiene. is merked other than "natural; raumatic avant, It's Modical Ex.	-	19a. Informant's Name/Relationship (19b. M	lailing Address	s (Street a				er, City or	Town, State, Z	ip Code)	
ΪŽ	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, If a Madical once."	ľ.	MR. THOMAS HARRIS	SON / SON	80	WISP	MOUN	CAIN	ROAD	, OAKLA	ND, 1	MD 215	50	
3altimore,	s 1 a of Hea itam othe	9 8	20a. Method of Disposition		20b. Place of D	isposition (Na.	me of other plac	e)	D	ate	20c. Loc	cation - City or	Town, State	
E	Page nent c int: if		1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Sther (Specif		GLEN HA			.	06/02	2/2005	GLE	N BURNI	E, MD	
ati	permit. Par Departmen Important: any injury once.		21. Signature of Funeral Service Licer	15 10		22. Name a	nd Addres	s of Facilit	y SIN	NGLETON	FUNI	ERAL HO	ME	
<u> </u>	89589		Kristine	out n	14319					, GLEN		IE, MD	21061	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.				_		r respiratory a	rrest,		Approximate Interval Between	1
	Physician		Immediate Cause (Final disease or condition	ACUTE	Acute	Kenai	ra:	Lure	e				Onset and Death	1
	/Medical Examiner		resulting in death)	Due to (or as a c										
-	LAdilline	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b	Diabet		llit	cus						
	led Isit	Examiner	Cause (Disease or injury	Due to (or as a c	Urinar		ct l	nfe	ctio	n				
	and and al-tra	хаг	that initiated events resulting in death) Last	cDue to (or as a c					C C T O	11				
8760,	ate be executed hysician and the burial-transit	dical E	· ·	a.										
687	tificate ng phy as the	edic		d										
Вох	leath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy						23	3d. Date of deli	very	
	that the death ed by the atte detached for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2 [4☐Pregnant at tim		3 ☐ Ectopic p 5 ☐ Other (sp						Month	Day Year	
O.	t the d by the tached	hys	9 🗆 Unknown	9□ Unknown										
'n	signed I	by F	Part II. Other significant conditions of	contributing to death but r	not resulting in th	e underlying o	cause give	n in Part I.	,	23e. Did t	obacco us	se contribute to	the cause of death?	?
) in	w requires been sign should be	ted						_		1 🗆 '	Yes 2□	No 3∏Pro	bably 4 Onkno	nwc
, 59	law r as be	Completed								24a. Was autoj		24b. Were aut	opsy findings availa	able of
R	The ate h page	Con								perfo	rmed?	death? 1 ☐ Yes		
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Na aria-ta						(Check only o				
of	physi this c	ို	1 ☐ Yes 2 ☑ No	Hospital: 1- Inpatient								□Other (Spec	ify)	
u C	ding F	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Tim Inju		28c. Injury Work	:?		8d. Describe i	how injury	occurred		
Division of Vital Records, P.O.	ttandi death. ctor: A / the fu	icat	2 Accident investigation 3 Suicide 6 Could not b		- At home farm			/es 2 □ I		est Location (Street and	Number or Ru	ral Route Number.	
Ο̈́	after Dirac	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (Specify)	, otreot, ractor	y, omeo			City or To		7,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0	arridato reginizar,	
	To the Hospital or Attanding Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending p completely tilled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifying Pt	ysician: To the best of r	ny knowledge, d	eath occurred	at the tim	e, date an	d place, a	nd due to the	cause(s) a	and manner as	stated.	
		Medical	Check only 2 Medical Exar	niner: On the basis of ex and manner stated	camination and/o	r investigation	i, in my op	inion, dea	th occurre	ed at the time,	date and p	place, and due	to the cause(s)	
	To the	ž	29b. Signature and title of certifier				c. License			1		signed (Month		
	(2)		berrle Icas	sahun	M.D.	1	000-	1547	3		MA	4 29	2005	
	((18)		30. Name and address of person who			pe, Print)			·				2005	
					rland	Bill	wa	4 51	1/Vez	r spri	nq	MB	20404	
Į.	Sta		JUN 1 7 2005	32. Registrar's		M. a								
4	Regist	al	A014 T 5002	BARRIAN A	J' ASSESSED	34								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Yeer THIE **Physician** 6:10 AM Leona Pauline Holland 7005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rising Sun

If Under 1 Year | If Under 24 Hrs.

State | Days | Hours | Min. Cecil Calvert Manor Healthcare Center 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2√2 F 88 218-58-7289 Yrs Director 1916 Marvland Nov. Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits ehow ir then "natural", or items 23e or 28a-f ehov the Neutical Examinat must be notified at 1 Yes 2 No Cecil North East Directo Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 U.S.A. 61 Willard Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker permit. Pages 1 and 2 should be tiled w Department of Health and Mental Hygier Importent: If item 27 Is marked other transpring or other treumatic event, Item 2006. 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fronia Klutcz Franic Fabiszak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 61 Willard Drive, North East, Md. 21901 Kathleen C. Amend/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 6/17/2005 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Busi a lille 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21014 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEMORRHAGIC /Medical Due to (or as a consequence of): **Examiner** HXPENTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) by the a 9 Unknown ρχ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si Completed CHRONIC DISTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 27 No 2 No this certificate 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deati To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie JUNE 14, 2005 H58419 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) 1881 TELEGRAPH ROAD, RISING SW, MD 2191 RODNEY DONHAM. Do 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 7 2005 Registrar

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DHMH 17 Rev 1/2001

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			1 - For State C	-	epartment of Health and Certificate of Death	Mental Hygie	ZUUG	20173
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	Robert Wayne Hall, Sr.				2, 2005	2250 M
	Examir	ner	4a. Facility Name (If not institution, give street and nu Laurel Regional Hospita		4b. City, Town, or Location of Dea	ath	4c. County of Death Prince Ge	2016
	Formul		5. Social Security Number 6. Sex	7. Age (In yrs. last birth		S. 8. Date of Birth		
	Funeral Director		219-12-2217 TX M 2 F	84 Yr	Months Days Hours Mi			lace (State or Foreign try) yland
	yland yland		10a. State 10b. County	10c. City, Town	or Location		1	Od. Inside City Limits
	Mar 0-1-0	to	MD Howard	Savage				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	23e	ai	8428 Woodward Street		20763		USA	
	er des	nue nue	Amed Fo		 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- into Rican, etc.)	14. Race - Americ Black, White,	
50	rs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Gi 3 ☑ Widowed 4 ☐ Divorced Year or D	² □No Army	1 ☐ Yes 2 No Specify:		Specify:	white
2-002p	72 hours after death with the Maryland Insturel', or Items 23e or 28e-f ehow Instal Ever instructive at Inclified at	ed	15. Decedent's Education	16a. D	Decedent's Usual Occupation	168	b. Kind of Business/Inc	dustry
<u> </u>	nin 72	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (()	Give kind of work done during most of w ife. DO NOT use retired)	orking		,
7	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23e or 28e-f ehow event, the Medical Erra: it retrinast be rediffed at	Completed	11	40, 317	Accountant		B & O Rai	lroad
<u> </u>	al Hy al Oth	Be (17. Father's Name (First, Middle, Last)			ame (First, Middle, Mai	den Sumame)	
yland	2 should be and Mental Is marked or reumetic ever	2	Louis Alexander Hall			e Hatfield		
N S	ges 1 and 2 should tt of Health and Men if Item 27 Is marke or other treumetic		19a. Informant's Name/Relationship (Type, Print) Cynthia Thorpe - daughte		Mailing Address (Street and Number or I 5 Baltimore Street			Code)
e,	1 and 2 Health tem 27		20a. Method of Disposition				c. Location - City or To	State
шшог	Pages nent of int: If it		1X Burial 2 ☐ Cremation 3 ☐ Removal from	State	Disposition (Name of crematory or other place)			
	- 분원급 .		 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee 		ridge Mem. Park 6/1 22. Name and Address of Facility		Elkridge,	
Ö	permi Depa Impo any i	1	Men	9	Gary L. Kaufman Fu 7250 Washington Bl	neral Home	@ Meadowri	dge MP, Inc. 1075
			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each					Approximate Interval Between
	Physician ¹		Immediate Cause (Final	monia				Onset and Death
	/Medical		resulting in death)	(or as a consequence of):			
	Examiner	Jer		al Fibrilat (or as a consequence of)				
9/00,	sate be executed oblysician and the burial-transit	dicai Examiner	that initiated events c.	(or as a consequence of)	ж			
O. Box o	law requires that the death certificate as been signed by the attending phys.	hysician/Me	in the past 12 months?	come of pregnancy birth 2 Fetal death ant at time of death bown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
as, r	wrequires that the de been signed by the s should be detached	by P	Part II. Other significant conditions contributing to d Anemia	eath but not resulting in t	he underlying cause given in Part I.		co use contribute to th	
ecords	w req	Completed	Degenerative Joint Disea	250		24a. Was an	24b. Were autor	osy findings available
ב	sicien: The law s certificate has t lirector, page 2 s	dmo		·		autopsy performed	prior to con death?	npletion of cause of
VII	en: Tiffical	0	Cerebrovascular Acciden 25. Was case referred to medical	-	26. Place of D	1 ☐ Yes 2 🔀	No 1 ☐ Yes	2 No
	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 🛣	npatient 2 ER/Outp	Othor	Home 5 ☐ Residence	e 6 Other (Specify)
5	ding Phys J. After this funeral di		27. Manner of Death 1 XNatural 5 ☐ Pending (Mon	of Injury 28b. Tin	ne of 28c. Injury at	28d. Describe how i		
VISION	andir sath. or: Af he fur	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
	el or Att. s after de sl Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of Injury - At home, faming, etc. (Specify)	1, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical ((Check only 2 Medical Examiner: On the b	best of my knowledge, asis of examination and/oner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and atta of certifier	1.0.	29c. License number		Date signed (Month, L	
			1 Some of	enough	1 1-42580	· [6	13.05	*
	541		30. Name and address of person who leted cause Parmjit Singh Aujla,	se of death (Item 23a) (Ty	ype, Print) napolis Road Suite	- 13. Rlado	nshura M	20710
	Sta	to		egistrar's Signature	, & figure	z 10, Diade		20110
	Registr			1005 Maries	, of Goden			

PORGAT 1002- 375/4 #50 435917.

9:15 р.ш.

JUNE 13, 2005

Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the 1
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		1 _ Stete	nd / Depa	artment of Health and I	Mental Hygi	ene	
		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	061	uncate of Death	2. Date of Death	g. No. 0 0 5	-3. Time of Beath
Physici		Betty M. Insley			June 1	3 2005 Year	9:15p ^M
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. Cily, Town, or Location of Deat		4c. County of Death	
	•	Stella MAris		Towson		Baltimo	ce
Funeral		1 M ADE	s. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
Director		215-24-9651 Usual Residence of Decedent	74 Yrs.		Aug. 31	,1930 MA	cyland
/land			ity, Town or Lo	ecation	-		10d. Inside City Limits
Man a-f-sh	to	MD Baltimore		Essex			1 ☐ Yes 2 🙀 No
ith the	Directo	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	intry?
ath w	rail	24 Nerbay Road		21221		USA	
itame	Funerai	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
D36	by F	1 ☐ Never Married		1 ☐ Yes 2⁄2 No Specify:		Specify: Whi	te
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or items 23a or 28a-1 show ont, ite Madical Examinar must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rting 1	6b. Kind of Business/li	ndustry
Marie 17	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			Killig (own home	
led will her the	So	8th	ноте	maker			
ed fa b e	Be	17. Father's Name (First, Middle, Last) Lenorad Lambie			ne (First, Middle, Mi		
Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Marylan ith and Mental Hygiene. 27 is marked other than "natural", or itams 23a or 28a-1 show traumatic event, the Madical Examinational be notified at	2	19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and Number or Ru	Schwar		in Codel
Z d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d		Thomas Insley/husband			altimore		p 0000)
s 1 ar f Hea f Hea item othe		20a. Method of Disposition 20b.		esition (Name of matory or other place)		0c. Location - City or T	own, State
Pages Pages nent of int: If it		1 E Dunai 2 Cremation 3 Intelligration 3 (ate			16/05	OwingsMil	ls MD
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service License	22	2. Name and Address of Facility	onnoll		
00 82E		J. Jerry Connells	1				meofEssex
		23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as cardia	or respiratory arres	a, rermore	Approximate 2 Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE	HEART	FAILURE			Oriset and Death
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	e	Sequentially list conditions, Due to for as a constant of the conditions of the cond	quence of				
uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events					
60, be executed sicien and burial-transit		resulting in death) Last Due to (or as a conse	equence of):				
8760 ate be e hysicien the buris	licai	d					
Box 687 leath certificate attending phys	Physician/Medi	IF FEMALE: 220 If you guttoome of progr					
death cert death cert a attendin	ian,	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	very Day Year
• 0 0 0	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown 9 ☐ Unknown	30	- Cities (Specify)			
# 2 B B	by Pr	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Cords, wrequires been sign should be					1 ☐ Yes	2 □ No 3 □ Pro	bably 4 X Unknown
VItal Records, P.O iclan: The law requires that the certificate has been signed by th rector, page 2 should be detache	ompieted				24a. Was an autopsy		opsy findings available ompletion of cause of
	Com				perform	ed? death? 【No 1 ☐ Yes	
Vital Rec siclan: The law certificate has l irector, page 2 s	Be (25. Was case referred to medical examiner?			ath (Check only one		
Physi Physi r this c	ပို	1 ☐ Yes 2 🗶 No 27. Manner of Death 1 ☐ Inpatient 2 [ER/Outpatier		lome 5 Residen	ce 6 COther (Special	(fy) HOSPICE
on of ding Ph. After the funeral	tion	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe nov	injury occurred	
DIVISION i or Attending after death. Diractor: Afte	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At	home, farm, str			et and Number or Rur	al Route Number,
DIV spital or A ours after neral Dirac filled in by	Certification:	4 Homicide determined building, etc. (Spec	city)		City or Town,	State)	
Division of Vita Physician: 24 hours after death. 2 hours after death. 9 Funeral Diractor: Atter this certificately filled in by the funeral director.		29a. Certifier (Check only (Ch					
To the Hos within 24 ho To the Fun completely	Medical	one) and manner stated.					
To COC	-	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month)	
1		30. Name and address of person who completed cause of death (Its	23a) /T	Print)	-1	6/14/	
4		DR. TARIQ MAHMOOD 2300 DULAN	, , , , ,		MD 2100	2	
1				I'KA KI)' LIMILINITIM		-	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	LEY RD. TIMONIUM	L. MD 2109	3	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month June 2005 **Physician** 14 5:10 P Daniel Joseph Januszkiewicz, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Nursing Center-Ruxton Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 21 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 931 **Funeral** 1 XM 2 ☐ F Months June Maryland 73 214-26-6864 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 🔀 No Director Baltimore Perry Hall Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 21128 U.S.A. 5 B Brook Farm Court Items 23e Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deet. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" any injury or other treumatic average. 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cable Elementary/Secondary (0-12) College (1-4or 5+) Set-Up Man 12th Grade Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frances R. Rataiczak James Januszkiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12650 Lee Ben Road, Kingsville, MD 21087 Daniel J. Januszkiewicz, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus 6/17/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON can cer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** comen to live Im Metustasis Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit mellimi Diabety Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 Yes Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Foursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this o 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division o the Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide To the Funeral Director of the Funeral Director of the Funeral Director of the Funeral of the Fu 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continer 10) 30. Name and a res of person who completed cause of death (Item 23a) (Type, Print) Mas 21204 TOWSUN Swite 509 DYIVE Osley 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar DHMH 17 Rev 1/200

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			1 - For State Registrar	State of M	arylanu /		tificate of I		ленан пу	Reg. No.	UUS	20176
	Physici	an	Decedent's Name (First, Middle,	,			1/ 1	Jr.	2. Date of De Month	eath Dey	Year	3. Time of Death
1	/Media	al	Edward 4a Facility Name (If not institution,	icKson			4b. City. Town. of	Location of Death	June	12_ 4c. C	2005 County of Death	8:10 PM
	Funeral	er	11/hEJohN5 H	OPKINS H	105 P 1 + 10 (In yrs. last b	oirthday) Yrs.	BCITIN If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De 01-02		9. Birthp	ace (State or Foreign
W	Director		Usual Residence of Decedent		07	113.		<u></u>	01-02	-1938	North	Carolina
	e Marylan ia-f show	ctor	MD 10b. County Mont	gomery	10c. City, To		Spring				10	0d. Inside City Limits 1 ☐ Yes 2X No
	death with the Maryland ms 23s or 28s-f show I must be notified at	Funeral Director	10e. Street and Number 3212 Beret Lane					0906		U	en of What Coun	try?
0000	be filed within 72 hours after death with the Marylan tal Hygiene. Ital Hygiene. Id other than "natural", or Hems 23s or 28s-f show event, the Medical Exandrer must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☼ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 ☐ Yes 2√57 If Yes, Give Year or Dates:		}	VV	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, of Specify: Wh	
2	within 72 ho ene. than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	16	a. Deced (Give I life. D	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work)	ing	16b. Kind	d of Business/Ind	lustry
7	e filed within at Hygiene. I other than vent, the Me	Com		College (1-4or) I	Nuc1e	ar Engin			ļ	Govermen	t
and		Be	17. Father's Name (First, Middle, L Edward Dickson					18. Mother's Name	S.cott		Gumame)	
>	s 1 and 2 should by I Health and Menta Item 27 is merked other traumetic e	To	19a. Informant's Name/Relationshi			b. Mailin	g Address (Street a	and Number or Rura			Town, State, Zip	Code)
, Mai	and 2 Balth a m 27 Is		Ellen M. Kendr	ck (wife)				ne Silve				
pairimore	Page nent o ant: If ury or		20a. Method of Disposition **CRBurial 2 Cremation * 4 Donation 5 Other (Sp.		Norb Park	of Dispos ery, crem eck	sition (Name of latory or other plac Memorial	06-	Date 16-2005		ney, MD	wn, Stete
Dail	permit. Departrimports any injugate		21. Signature of Funeral Service 4		480287]	Name and Addres	ral & Cre	emation	Serv	ices	
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a	ne. Le cel	not ente	ir the mode of dyin		or Spri	ng, M irrest,	D 20910	Approximate interval Between Onset and Death
	Examiner		Sequentially list conditions,	graft	a consequence	LS	host d	isease				5 moneths
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c neur	a consequence a consequence							3 weeks
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ecords, r	quires that an signed build be det	by	Part II. Other significant condition	s contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did t		/	e cause of death?
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VII		o Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Othe	26. Place of Death				
0	g Phys er this eral di	-	27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 ER/C	Time of	3□ DOA 28c. injury Work	4 [] INUISING NO	me 5 Resi 28d. Describe		Other (Specify, occurred)
DIVISION OF	ospital or Attending P hours after death. unerel Director: After I iy filled in by the funera	Certification:	1 Matural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion t be 28e. Place of Inj		Injury farm, stre	M 101	res 2 □No	28f. Location (. City or To	Street and	Number or Rural	Route Number,
5	To the Hospital or Attending the Hospital or Attendation to the Funeral Director: completely filled in by the	<u>a</u>	29a, Certifier 1 Certifying	Physician: To the best	of my knowledg	ge, death	occurred at the tim	e, date and place,	and due to the	cause(s) a	nd manner as sta	ited.
**	To the Howithin 24 h To the Fur	Medic	one)	ceminer: On the basis of and manner st	i examination a ated.	mazor inv						
	To with		29b. Signature and title of certifier	سر مسریس	5		29c. License			June	signed (Month, D	200
	10		30. Name and address of person we Rosalyn Juergens	no competed cause of c	leath (Item 23a	Str.	et Johns	Hopkins	CRB-	186	Baltinure	21231 Maryland
	Sta Registr		31. Date filled (Month, Day, Year)	7 2005 32. Registr	ar's Signature	4 1	Sparke	Hopkins				J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Ruth W. Kelly 06/14/2005 5:00am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1410 Andre Street Baltimore MD N/A 7. Age (In yrs. last If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 07/31/ Birthplace (State or Foreign Country) last birthday) 5. Social Security Number 213-01-2165 **Funeral** Months Hours 1 ☐ M 2 🔀 F **Director** MD Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at MD N/A Baltimore MD IXXX 2 □ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1410 Andre Street 21230 USA or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XXX If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Specify: white Specify 2 3 XXXX owed 4 ☐ Divorced "netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "rany injury or other treumatic avent the state. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 5 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unk. Schools Julia Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) F. Michael Kelly / Son 1331 Richardson Street, Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Tabarial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 06/ 17/2005 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 Doda, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on ear _lin_ Denot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician lears /Medical Due to (or as a misequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 No 2X No ol or Attending Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) X No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) P 1 🗌 Yes nours after death.
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filled in by the funeral di this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Magner of Deat Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide Fo the Hospitel within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier paul place Bollim MO21202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2005

32 Registrar's Signature

		_	For State Registrar			/larylan		artment of H			R	eg. No.Z.	05	2017	18	
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036	ours after el', or ite	Completed by Funeral	11. Marital Status 1 ☑ Never Marrid 3 ☐ Widowed		12. Was Deceder Armed Forces d 1 Yes 2 1 If Yes, Give Year or Dates	s?] No	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🎎 No	ispanic Orig in, Mexican, Specify:	gin? (Specif , Puerto Ric	fy Yes or No- can, etc.)		ace - Americ ack, White, e ify: Whi	etc.		
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	Funeral Director		5. Social Security Number 6. Security Number 12 17-60-2475 Usual Residence of Decedent	7. Age (In yrs. las M 2□ F 52	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 06/19/	rth ay, <i>Year)</i> 1952	9. Birthpl Count Mary	ace (State or Foreign try) Land
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Dalitimo	permit. Pages Department of I Important: If its any injury or of once.		21. Signature of Funeral Service License	90	22. Name and Addre	ss of Facility E.	F. Las	sahn Fu	neral	Home, P.A.
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Š,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	caiE		,						
	rtificat ng phy as the		IF FEMALE:							
200	attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3 Ectopic pregnancy	/			ate of deliver fonth	y Day Year
į	the de	Physiclan/Med	1 □ Yes 2 □ Y 9 □ Unknown	4□Pregnant at time of deat 9□ Unknown	h 5 Other (specify)					
r V	es that gned b	by Pi	Part II. Other significant conditions con		ng in the underlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to the	e cause of death?
5	requir een si bould i		Ketropent				1 🗆	Yes 2 N	3 🗌 Proba	ıbly 4 □Unknown
necolds,	ne law shasb ge 2 s	ompleted	Hematon	16			24a. Was auto		. Were autop prior to com death?	sy findings available inpletion of cause of
Vilal	Physician: The lav this certificate has al director, page 2	e C	25. Was case referred to medical			26. Place of Death	1 Yes	2 100	1 ☐ Yes 2	2□ No
5	hysici his cer I direc	To B	examiner? 1 ☐ Yes 2 ☐ Yo		VOutpatient 3□ DOA Oth				ther (Specify)	
5	ding Ph h. After th funeral	lon:	27. Manner of De th 1 Satural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of 28c. Injury Wor 1	yat 2 k? Yes 2 ☐ No	8d. Describe	how injury occu	irred	
VISION	I or Attendi after death. Diractor: A I in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home			8f. Location (Street and Nun	nber or Rural	Route Number,
5	rs after all Dire	Certification:	4 Homicide	building, etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phyon to the Funeral Director. After this certificate has been signed by the attending phyon physician by the funeral director, page 2 should be detached for use as the application.	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the tin n and/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the d at the time,	cause(s) and n date and place	nanner as sta , and due to	ted. the cause(s)
	To the To the	Me	29b. Signature and title of certifier	1.	29c. Licens	e number		29d. Date sign	ed (Month, D	ay, Year)
	1		Jasmyll	M.D.		5947		June	13	2005
1	1		30. Name and address of person who co	mpleted cause of death (Item 23	3a) (Type, Print) Of Marvla	ud 22.	South	bree	110 54	Baltimore
	, Sta	tė	31. Date filed (Month, Day, Year) JUN 1 7 200	37 Registrar's Signatur	of Haryla	THE LE	SUCCEPT	Unce	VIC -	LALL A LCINC
	Registr	ar	JON 1 7 200	Blown A	GOERE					

			State of Ma				•	•	bie.	
			1 _ State	-	nd / Department of Health and M Certificate of Death			20115 20180		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death		Reg. No.		3. Time of Death	
	Physic /Medi Examii	an	EMILY		KUSHNICK		Month	Day	Year I lo au	
			4a. Facility Name (If not institution, give street and number)			or Location of Death	Lune	10 20 4c. County		
	Exami	ler	Sinai Hospital of Balt	illore.	Baltine				N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth) Vaar)	Birthplace (State or Foreign Country)	
7	Director		144-26-3585 1□M 27F	69 Y	rs. Months Days	Hours Mill.	8. Date of Birth	1935	NJ	
-3	DC *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits	
Enuil	eho.	'n	MD BALTIMORE						1 ☐ Yes 2 ☑ No	
\overline{n}	tha h	Funeral Director	MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code					10g. Citizen of V		
1	with Sa or		7021 PHEASANT CROSS DRIVE 21209					. 09. 01	USA	
5	death ms 2:	era	11. Marital Status 12. Was Decedent Armed Forces?	ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race	e - American Indian,	
ع ج	buts after death with the Marylan el; or items 23a or 28a-f ehow Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 M If Yes, Give	lo		an, mexican, Puerro Specify:	Hican, etc.)		k, White, etc.	
rs kusknick 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. then "naturel", or Items 23e or 28e-f ehow ent, to Madical Examiner must be natified at	Completed by	3 X Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 No	эрвспу.		Specify	WHITE	
₹ <u>₹</u>	in 72 hours "naturel",	iete	15. Decedent's Education (Specify only highest grade completed)	(Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Bu	usiness/Industry	
4 5	d withir giene. rr than	dm.	Elementary/Secondary (0-12) College (1-4or 5	+)	ENT	u)		TRAVEL		
2 5	ba filed withital Hygiene. d other than	To Be Co	17. Father's Name (First, Middle, Last)	710		18. Mother's Nam	e (First, Middle,		e)	
www (thould band Mental marked o		JACOB	FE	MAN	MARIE			ROBINSON	
knewn	should and Men is marke		19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address (Street	and Number or Rur	al Route Numbe	r, City or Town,	State, Zip Code)	
~~	C = 14 F		JODI MAILMAN / DAUGHTER	The second secon	705 HUNTWO	CA TANTO MA				
2	Pages 1 ar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1	Disposition (Name of , crematory or other plac		Date		City or Town, State	
i i	t. Pa tmen tant: tjury		` 4 ☐Donation 5 ☐ Other (Specify)	BALTIMO	RE HEBREW (ERSTOWN, MD	
Patient k Baltimore	permit. Pages Department of important: if i any injury or once.		21. Signature of Tuperal Service Licensee		22. Name and Addre	50			ROS., INC. LE, MD 21208	
2			23a. Part1. Enter the obease, or complications that caused	the death. Do no					Approximate Interval Between	
	Physician		Onset and Death							
	/Medical		disease or condition resulting in death) a. Harmon Age Stroke Due to (or as a consequence of):							
	Examiner		Sequentially list conditions b. Sugarus	therateu	tie leagu	Valion	State			
No.	pe is	Examiner	Sequentially list conditions, it airy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of	uence of):					
la	be axecuted ician and burial-transit	хаш	that initiated events resulting in death) Last Due to (or as	a consequence of	n.					
760	e be axecuted sictan and burial-transit	caiE								
687	ificate g physias the		0.							
×	anding use	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		2 Catalia			23d. Dat	e of delivery	
ď	death	Physician/Med	in the past 12 months? 1 Yes 2 No					Month Day Year		
0	at the by th	hys	9 □ Unknown 9□ Unknown							
v.	res th igned be de	by	Part II. Other significant conditions contributing to death be	ut not resulting in t	the underlying cause giv	ven in Part I.			ribute to the cause of death?	
0.0	requi	Completed	Amal filmulation	1			1 🗆 Y		3 Probably 4 □Unknown	
200	e law	ηpie	coronaly artely diseas	e, hyp	xetension)	24a. Was a autop: perfor	in 24b. V	Were autopsy findings available prior to completion of cause of death?	
-	r: Th icate r, pag		hypercholesterlients, anabetes mellettes 10 yes 2					2 X No 1 ☐ Yes 2 X No		
; <u></u>	sicier certif	Be c	25. Was case referred to medical examiner? Hospital: Structure of FD0 with a							
Č	Phy ar this eral d	n; To	27. Manyfer of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							
į	nding ath. r: Afte e fune	aţioi	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No							
Division of Vital Becords. P.O. Box 68	Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State)						er or Rural Route Number,	
<u> </u>	itel on ris aftre Dia Dia Dia	Cer								
	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edicai	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and manner stated.							
_	To the vithin To the comple	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed	(Month, Day, Year)	
			Myreni, MD		RES	-000		Iune,1	0,2005	
Myreni, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avjana Myreni, MD Strai Hozkital of Baltinuse										
0.000										
	Sta Regist		JUN 1 7 2005	ai s Signature	seles.					
	ricgist	reir	CONT. 1 LOOD DEPOSITOR .	as James	-					

DHMH 17 Rev 1/2001

FRANCES HENPIE LAMACTINA

			Please 1	ype or Prir					•		gible.	
			1 _ For	State of Ma	aryland /		tment of F <i>ificate of</i>		Mental Hy	(7) (7)	275 F1 04	
			Registrar 1. Decedent's Name (First, Middle, Last	<u> </u>		Cert	ilicate of	Dealli	2. Date of D	Reg. No.	45	12 the 1 the
	Physicia	an	1. Decedent's Name (First, Middle, East,	2 .	10	mer	tina		Month	Day	/ Year	1950 M
	/Medic		4a. Fecility Name (If not institution, give	vie Ha	Con	mev	4b. City, Town, c	r Longtion of Do	oth Y	40 COV	oty of Death	(1)
	Examin	er			Center	_	40. City, Town, C	in Location of De	diii		acco	11
	Formul		5. Social Security Number 6. Seg	J. FU!	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi		-	place (State or Foreign
	Funeral Director			M 217 F	79	Yrs.	Months Days	Hours Mi	n. 8. Date of Bi (Month, D			place (State or Foreign ntry) yland
-			Usual Residence of Decedent			1			1110 20	1920	PIOL	YTAIIU
	show	١.	10a. State 10b. County		10c. City, To						1	10d. Inside City Limits
:	16-fs	ᅙ	MD Carrol	L	Tan∈	ytow	n					1 ☐ Yes ŽXNo
3	or 28e-f	<u>Sire</u>	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	238	Funeral Director	5130 Haines Lane				217				USA	
	1/2 nours arter death w "netural", or iteme 23a dicel Examiner must b	nue	11. Marital Status	12. Was Decedent if Armed Forces?		13. W	as Decedent of H Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	o- 14. F	Race - Ameri Black, White,	
3	ori	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ h	No	11	⊒Yes 2¶∑No	Specify:		Spe	city: whi	te
3	turat'	b d	15. Decedent's Edu	Year or Dates:	16	a Decede	nt's Usual Occup	nation		16h Kind o	f Business/In	duetor
2	n /2	Siet	(Specify only highest grad	e completed)		(Give k	ind of work done O NOT use retire	during most of w	vorking	TOD. KING O	, D031110334111	dustry
1	thar thar	Completed	Elementary/Secondary (0-12) unknown	College (1-4or 5	5+)	Balt	imore Ci	ty Poli	ce	Local	Govern	nment
3	Hyg Other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	e, Maiden Sun	name)	
3	Med be	To B	Harry Subock					Molly D	eacon			
2	s 1 and 2 should be lied within 72 hours after death with the maryland. Health and Mental Hygiene. If Health and Mental Hygiene. If the and the marked other than "netural", or iteme 23a or 28e-f show other traumetic event, the Madical Examiner must be notified all	_	19a. Informant's Name/Relationship (T)						Rural Route Numi		wn, State, Zip	Code)
	and 2 ealth a m 27 is		Rose Emanus - dau	ghter	51	.30 н	aines La	ine, Tan	eytown, 1	MD 217	787	
	s 1 a of Hei item othe		20a. Method of Disposition		20b. Place cemet	of Dispos	ition (Name of atory or other pla	ce)	Date	20c. Location	on - City or To	own, State
2	rages nent of h int: if ite iry or of		1 ☐ Burial ②XXCremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			-	Wash. C		17/ 2005	Lau	rel, M	D
	그 돈 뿐 글		21. Signature of Funeral Service Licens			22.	Name and Addre	ess of Facility		0 34-		Jana MD. Trans
Š	Departiment important		lavelin						neral HC vd., Elk			dge MP, Inc. 1075
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	the death. Do							Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition			CTOSS	CTIVE	PULMO	NARY I	SEAS	E	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence	e of):	7700	,	NARY I			7
	Examiner		Conventially list conditions	COR	ONARY	1 10	Tary .	DISEASE	7			YEARS
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	w fequires that the death certilicate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
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	ate b hysic the b	Sica		d								
	ing p e as	Physician/Medical	IF FEMALE:									
	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal dea		Ectopic pregnanc	y		23d.	Date of deliving Month	ery Day Year
5	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5∐	Other (specify) _					
	nat tr d by detac		Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the un	derlying cause on	ven in Part I	23e. Did	tobacco use o	ontribute to t	he cause of death?
2	signe d be d	l by					son, and second gr		-	Yes 2 □ N		bably 4 ⊡Unknown
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ט ע	Blaw hast	id u			,				24a. Wa	s an opsy ormed?	prior to co death?	opsy findings available ompletion of cause of
5	cate pag	S							1 ☐ Yes	2 No	1 🗆 Yes	2 No
	certifi sector	Be	25. Was case referred to medical examiner?	Hospital:			O++	26. Place of C	eath (Check only	one)		
5	this aldir	J.	1 Yes 2 No	28a. Date of Inju		Outpatient . Time of	3L DOA	4 Nursing	Home 5 Res	how injury oc		(y)
5	After After funer	lo	1 (Danatural 5 Pending	(Month, Da	y Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2□No	200. Describe	rilow injury oc	curred	
2	death death stor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	ury - At home	farm stre			28f. Location	(Street and N	imber or Rur	al Route Number,
2	or A Direction by	it a	4 Homicide determined	building, et	c. (Specify)	idimi, stic	or, radiory, direct		City or To	wn, State)		,
-	To the Hosylfel or Attending Physicien: The law requires that the death certificate within 24 hours after death. within 24 hours after death. conclude Funder Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the I		29a. Certifier Tertifying Phy	sician: To the best	of my knowled	ge, death	occurred at the ti	me, date and nia	ice, and due to the	cause(s) and	manner as s	stated.
	24 h 24 h 8 Fur etely	Medica	(Check only 2 Medical Exam	ner: On the basis o and manner st	f examination a	and/or invi	estigation, in my	opinion, death oc	curred at the time	, date and pla	ce, and due t	o the cause(s)
	To th within To the	Me	29b. Signature and title of certifier				29c. Licen:			29d. Date sig		
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	\mathcal{O}_{i}		30. Name and address of person who c	,) (Type, F	rint)					
			WILDHE FUL	MD	2.9	15 5	tomer	100	54.TE 3	07 4	EST//	NSTER MO
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	K	Brance					
	Registr		11 IN 1	7 /11111 🕨 🏄	F-18.20 1	AJ .	No. of London					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 06 Month 13^{Day} 2005^{Year} **Physician** Vito L. Linsalata 0:700aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 321 West University Blvd. Apt 314 Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-19-1931 **Funeral** Birthplace (State or Foreign Country) Days Hours 12 M 2□ F 73 579-38-2901 Director New York Usual Residence of Decedent I and 2 should be filed within 72 hours atter death with the Maryland Health and Mental Hygiene.

em 27 ia marked other than "natural", or Itema 23a or 28a-f show the reaumatic event, the Medical Emit ar mast lex notities at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Director Montgomery 1 ☐ Yes 2 ੌ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 West University Blvd Apt 314 20901 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 Security Guard Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leonard V. Linsalata Lucarelli ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Nicholas Linsalata (brother) 3512 Stonehall Dr. Beltsville MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 06-15-2005 Beltsville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Rapp Funeral & Cremation S
933 Gist Ave Silver Spring

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Rapp Funeral & Cremation Services 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Finaf 10 Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): Box 68760. the IF FEMALE esn 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 2000 Division of Vital To the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending June 13 2005 unknowin palcony nom after death. Director: A 1 ☐ Yes 2 X No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number City or Town, St. te) filled in by 4 Homicide City or Town, St. to) Afar finen-University blud, Silver S TME within 24 hours 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier diroid 30. Name and address of person who completed atricia lomsko Vay 31. Date filed (Month 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylar		artment of Hea		ntal Hygien Reg. N	4000	20183
			Decedent's Name (First, Middle, Last)					Date of Death		3. Time of Death
ı	Physici		THERECA	MARIS	1-5.W	2		Month D	ay Year	17:30 PM
	/Medio Examin		4a. Facility Name (If not institution, give stre	et and number)	Minday Markey	4b. City, Town, or Loc		1	c. County of Dee	th
			13/8ms11: 8 Lo	>RI		PARKVILI	S	(milled	C.152
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		Under 24 Hrs. 8. ours Min.	Date of Birth Month, Day, Year	9. Bir	thplace (State or Foreign
	Director		312 PF 030P 111W	30 F 748	Yrs.	Wortus Days Th	-	2P1 11 Km	BO CA	WLAND
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c Gi	ty, Town or Lo	cation				10d. Inside City Limits
	sho	ក	Musik a Date	0.) ~) < ~					1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number	12	AKKY	10f. Zip Code		100.0	itizen of What Co	
	with la or		7 2 1: 22 2 2 1			2 - 2 - 2		109.0	1 1 0 0	ontry :
	leath	Funerai	11. Marital Status 12.	Was Decedent Ever in U	J.S. 13. V	Was Decedent of Hispan	nic Origin? (Specify	Yes or No-	14. Race - Ame	rican Indian.
10	ritter	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No	1	Was Decedent of Hispar f Yes, specify Cuban, M	exican, Puerto Rica	in, etc.)	Black, Whit	
ő	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2月 No Sp	pecify:		Specify:	Hiro
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be natified at	Completed	15. Decedent's Educat (Specify only highest grade of	on ompleted)	16a. Deced	ient's Usual Occupation kind of work done during	a most of working	16b.	Kind of Business	Industry
2	thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	g most of working			
	filed with Hygiene. other thai	S	-21/61		SUL	5 PESCE, AT	3	3.6	of THOS	3172 MARM
Maryland	be fill d oth even	Be	17. Father's Name (First, Middle, Last)		~ \ .	18.	Mother's Name (Fi	rst, Middle, Maide	n Sumame)	
Ž	should be Ind Mental I	ို	LHARLES ELL		cksor	,	VERON	ICA L.	1 Why	
Nai	12 sho h and 7 is ma traum		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street and I	Vumber or Rural Ro	ute Number, City	or Town, State, 2	Zip Code) 3,0314
	1 and Health tem 27 othar tr		20a. Method of Disposition	20b F	Place of Dispo	sition (Name of	Date	ACKYILL SOOL	ocation - City or	Tour State
٥	Pages nent of I int: If its		1)⊠ Burial 2 ☐ Cremation 3 ☐ Rem	- 1		natory or other place)	JUNET		ocation - City of	Town, State
altimore,	permit. Pag Department Important: I any injury o		' 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funefal Service Licensee	TR	2KWOG	Name and Address of	300	IA	SKritte	1 60,00
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or othar traumatic event, the Madical Examinar must be nutified at once.		21. Signature Di Pullerali Service Elicensee		2	CUP LAHE	TOE P	welling		3/23/4
			23a. Part1. Enter the disease, or complicat	ions that caused the deat	th. Do not ente	er the mode of dving su	-0 RO 1RO F	spiratory arrest	Willia 1	Approximate
П	186-14-00		shock, or heart failure. List only one of	aùse on each line.	100 272			spiratory arrost,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)		ung	Concer				2 maths
Н	Examiner			Due to (or as a conseq	uenc ou					
	3818	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	(uence of):					
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
o Î	exec an an rial-tr	Еха	resulting in death) Last	Due to (or as a conseq	(uence of):					
8760,	icate be executed physician and s the burial-transit	dical	d							
9	ntifice ng ph s as tl	Med	IF FEMALE:							
Box	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 poonths?	If yes, outcome of pregna 1 Live birth 2 Feta		Ectopic pregnancy			23d. Date of del	•
o.	e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d 9 Unknown	death 5□	Other (specify)			Month	Day Year
۵.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contrib	urting to doath but not rec	ulting in the ur	ndarh ing gayas giyas in	Dort I	23a Did tabassa	uso contributo to	the cause of death?
Š	ires t signe		Tarris, Other significant conditions contrib	dung to death but not res	alling in the di	idenying cause given in	raiti.		_	obably 4 Dunknown
0.0	w requir been si should	etec								
3ec	e law has l	Completed						24a. Was an autopsy performed?	24b. Were au prior to d death?	topsy findings available completion of cause of
a	ician: The l certificate ha rector, page							1□ Yes 2⊠N	1 Yes	2 No
Ĭ	ysician: is certific director,	o Be	25. Was case referred to medical examiner?	oital:	lenia		Place of Death (Cf			32.1 N
ot	Physic rithis aral di	\vdash	10:48 2/5/10	28a. Date of Injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury at	Nursing Home	Describe how inju		cify)
O	nding Ph th. : After th s funeral	tior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes		,	,	
Division of Vital Records,	Atter r dea actor by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stre	eet, factory, office				ral Route Number,
	s afte	Certification;	4 Homicide determined	building, etc. (Specif	(y)			City or Town, Stat	e)	
	hours hours unera ly fille	cal	29a. Certifier Certifying Physici	en: To the best of my kno	owledge, death	occurred at the time, da	ate and place, and	due to the cause(s	s) and manner as	stated.
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director, is	ledical	une)	and manner stated.	ation and/or inv					
	To To CONT	Σ	29b. Signature and ofte of certifier	land ma		29c. License nun	nber	29d. Da	ate signed (Month	n, Day, Year)
	9		pay all	Uno IN		P56	7 < 7	igi	1E 14	2008
	12		30. Name and address of person who comp	leted cause of death (Item	n 23a) (Type, I	Charles 57	#25	BARM	N MO	21204
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	10/0/01		J.50, 7.		- (- /
	Registr		JUN 1 7 2005	Bear D'	Aners	مع				

			1 - For State of Maryland / State of Maryland /		artment rtificate			and M		Rag. No	05	20184
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Arylene T. Leonard						2. Date of De May 30		Year	3. Time of Death 6:55pm M
	Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		Tak	oma	Park				y of Death	ry
	Funeral Director		5. Social Security Number 578-74-9223 Usual Residence of Decedent	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da NOV •	th 7° 1955	9. Birth	place (State or Foreign ntny) ntngton, DC
	Maryland -f show	tor	10a. State 10b. County 10c. City, To	wn or Lo						-		10d. Inside City Limits 1 Yes 2 No
	ath with the Marylan 123a or 28a-f show ust be rectified	Funeral Director	10e. Street and Number 4907 Eastern Avenue #104		10f. Zip	Code 20782	2			10g. Citizen of United		
980	72 hours after death with the Maryland natural; or itema 23a or 28a-f show dieal Eva of rest fer rediffed at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deced If Yes, spec	_	spanic Ori n, Mexicar Specify:	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	5 14. Ra Bla Speci	ck, White,	can Indian, etc. ack
21215-0036	within ene. than "	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Sa. Dece (Give life.	dent's Usua kind of wor DO NOT us bled	l Occupa k done d e retired	ation during mos)	t of work	ing	16b. Kind of E		ndustry
and ;	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) Joseph W. Teague						s. She	, Maiden Suma Oherd	me)	
Maryland	s 1 and 2 should be f Health and Mental H item 27 is marked ot othar traumatic ever	-	19a. Informant's Name/Relationship (Type, Print)	9b. Maili 1907	ing Address Easte	(Street a	and Numbe Avenu	e #1	al Route Numb	er. City or Town	, State, Zij	²⁰⁷ 82
Baltimore,	0 0		1 Rurial 2 PC Cromation 3 Removal from State Ceme	itery, cre	osition (Name In Parallel	ther plac			Date 7,200	20c. Location		own, State Maryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	2	2. Name an	d Addres		AU		oyster f t. NW Wa		al Home gton, DC
	Pnysician		23a. Part. Enter the disease, of confedications that caused the death. D shock, or hear failure. List only one cause on each line. Immediate Causer (Final disease or condition	_		#010mm	g, such as		or respiratory a	rrest,		Approximate 1 1 Interval Botween Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of the conditions	2	AR	2 +)	47	TH	MIA	}		
8760,	cate be executed obly sician and the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. C. R. F.) Due to (or as a consequence)) S					-140 D156	ER FASE		
Box 6	ne death certifii the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal decedent in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3[□Ectopic pro □ Other (sp						ate of deliv	ery Day Year
ds, P.O.	luires that the signed by ald be detact	b	Part II. Other significant conditions contributing to death but not resulting	g in the t	underlying ca	ause giv	en in Part I			tobacco use cor Yes 2 □ No		the cause of death?
Il Records,		Completed							24a. Was auto perfe 1 🗆 Yes		Were autoprior to codeath?	opsy findings available ompletion of cause of
of Vital	ysician is certif director	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{NNo} \) Hospital: 1 \(\text{Stinpatient} \) 2 \(\text{ER/} \)	Outpatie	int 3 DO	A Oth	0.51		h <i>(Check only</i> ome 5 ☐ Res	one) idence 6 □Ot	her (<i>Sp</i> eci	fy)
ion o	utanding Ph death. ctor: After thi y the funeral		27. Manner of Death 1★ Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	b. Time o Injury	of 2	8c. Injun Worl	yat k? Yes 2□	No	28d. Describe	how injury occu	rred	
Division	al or Atta s after de il Directo od in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of tnjury - At home building, etc. (Specify)	, farm, st	treet, factory	, office			28f. Location (City or To	Street and Num wn, State)	ber or Rur	al Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Medical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled and manner stated.	dge, dea and/or ir	th occurred nvestigation,	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and m date and place	anner as s , and due t	stated. to the cause(s)
		M	29b. Signature and title of certifier Claudian Sellatia	2-1			to number	85	2	29d. Date sign		Day, Year) - 2005
	7		30. Name and address of person who completed cause of death (Item 23 Chandra S. Konapati 7207-B H	lanov	er Pa	rk V	Nay Gi	reen	belt, M	D 2077	0	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 7 2005 2. Registrar's Signature	April	who .							

		·	1 - For State Registrar	State of M	laryland	-	artmen rtificat			and M		Reg. No	005	20185
	Physici		1. Decedent's Name (First, Middle, La Anne Temple Moon	st)							2. Date of Dea	ath 1 ^{Day}	2005	3. Time of Death 3:55aM
	/Medic Examin		4a. Facility Name (If not institution, giv 419 Russell Ave)				Location o			4c. C	County of Deat	h
	Funeral Director		5. Social Security Number 340–26–4412 Usual Residence of Decedent	Sex 7. A I□M 2180 F	ge (In yrs. Ia 76	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Dat 05-06	192	9. Birt 9. M11	hplace (State or Foreign ountry) nnesota
	Maryland	tor	10a. State 10b. County MD Montg	omery		Town or Lo								10d. Inside City Limits 1 AYes 2 □ No
	or 288	Director	10e. Street and Number				10f. Zip					-	en of What Co	ountry?
	eath w	eral	419 Russell Ave	#205 12. Was Deceden	+ Ever in II 9	2 13 1	Was Docor		20877		ocifu Ves or No.	US	A 4. Race - Ame	nican Indian
980	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	?		f Yes, spec		Specify:	, Puerto	ecify Yes or No- Rican, etc.)		Black, White	
1215-0	within 72 ho ene. than "natur ha Medical	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	life. I	kind of wor DO NOT us	rk done a se retired,	lu <i>rina</i> most	t of worki	ng		d of Business/	Industry
and 2	be filed tal Hygi d othar	Be	17. Father's Name (First, Middle, Last Harry Samuel Tem			nome	emake	r			(First, Middle,	Maiden S		
	nd 2 should Ith and Men 27 Is marka r traumatic	ပ	19a. Informant's Name/Relationship (Christopher W. M	Type, Print)					nd Numbe	r or Rura	Gaither	r, City or	Town, State, 2	
more,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		Ce	ace of Dispo metery, cren sapeal	natory`or o	ther place			7-2005		ation - City or	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Dice		W0038						emation er Spri			2
Mr.	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Metasta a. Due to (or as	atic C	Carcino						rest,		Approximate Interval Between Onset and Death 2 years
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):								
.O. Box 6	the death certifi y the attending p tched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2反 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pr Other (sp					23	d. Date of deli Month	ivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of COPD, Atheros			_		-						the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed											prior to death?	topsy findings available completion of cause of 2 No
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r.		(Check only o			
of	ding h. After fune	tlon: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inj (Month, D		ER/Outpation 28b. Time of Injury		8c. Injury Work	at A D NU		me 5 🔀 Resid 28d. Describe h			cify)
Division	iplial or Attanding ours after death. laral Diractor: After filled in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Ir	njury - At hor etc. (Specify)	me, farm, str	eet, factory	, office			28f. Location (S City or Tow	Street and in, State)	Number or Ru	iral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example	nysician: To the besi miner: On the basis and manner s	of examinati	vledge, death ion and/or inv	n occurred vestigation,	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
)	To To Mithin	W	29b. Signature and title ancertifier	Meyer	M	7	290	D3	number L840				signed (Mont) 6-16-2(
	/0		30. Name and address of person who Wayne Myer 9715	Medical Co	enter	Dr. S	te 21		ckvi1	1e M	ID 20850)		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 17	2005 32 Aegist	trar's Signat	F A	enter							

State of Maryland / Department of Health and Mental Hygierie (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 13, 2005 B:30P /Medical John C. McGuire 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 120 M 2□F **Funeral** Days Months Hours Director 58 08/30/1946 218-46-4977 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutibed at 1 Yes 2 No Director MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ or Items 23e 2522 Canterbury Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced neturel', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Retail Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 Is marked other th Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eunice Elizabeth Wheatley John Charles McGuire, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m eny injury or other traum once. Kevin Smith 2522 Canterbury Road Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jun 15 Beltsville, Maryland Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service Licensee

Stephen Johnson M00382 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a GANGRENOUS BOWEL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or damping Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transit and that initiated events Box 68760, resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy atter in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENDOCARDITIS MITRAL VALVE 2 D No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? SEVERE CORONARY ARTERY DISEASE 24a. Was an has autopsy performed? Yes 2 No 2 No 1 Yes I Yes Division of Vital Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Onte of Injury (Month, Day Year) 27. Mayiner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P after death. I Director: After After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 24034 who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 TIMOTHY LOW. M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 1 7 2005 State Registrar

			i icase i	State of Man				-		egible.	
			1 - For State Registrar	Otato of Mar	-	rtificate of		-	Reg. No.	005	20187
	Physici		1. Decedent's Name (First, Middle, Last)	MAURE	ANTZ			2. Date of Da. Month	ath . Dav	200'S	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)	1 -	4b. City, Town, o	r Location of Death			ounty of Death	
1			5. Social Security Number 6. Sex		In yrs. last birthday	If Under 1 Year	NLME If Under 24 Hrs.	8. Date of Bin	В	altimore	City
L	Funeral Director		216-24-1240	M 2⊠F 7!		Months Days	Hours Min.	Jan	y, Year)		ace (State or Foreign try) Cyland
	yland iii		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				10	Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	Director	Maryland Baltimore	e City	Balti	more City	/		10a Citize	en of What Coun	XXYes 2 □ No
	3a or		4203 Kolb Avenue			2120	16		-	SA	u y :
	ams 2	Funerai		2. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H		pecify Yes or No o Rican, etc.)		Race - America Black, White, 6	
5-0036	hours after ural', or Ita	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	t □ Yes 2 x X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X No	Specify:			Specify: Whi	
- - -	27 BE 28	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deca (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of world)	king	16b. Kind	d of Business/Inc	lustry
7 7	giene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		Clerical			R	etail	
/land	be file ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	,	Maiden S	lumame)	
7	should be ind Menta i marked umatic ev	우	Nicholas Meile 19a. Informant's Name/Relationship (Type	oe. Print)	19b. Maili	ng Address (Street		Brown	er City or	Town State Zin	Code)
Z	nd 2 ilth a 27 ts r tra		Thomas G. Maykrant	lvenue Ba			·				
Baltimore,	iges 1 a nt of Hea i. If item or othe		20a. Method of Disposition 1 ☐ Burial 2√Cremation 3 ☐ Re	ce)	Date		ation - City or To				
	rtmer rtant rtant		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Metro Cr	ematory 2. Name and Addre		0~05		imore, N lair Rd.	
n D	Depa Impo any i		Louald C	Lasser	hu i	Lassahn F				ore, Md.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		c Obstur						Approximate Interval Between Onset and Death OUTCUS
,00/	e be executed rsician and burial-transit	cai Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c							
O. Box 68	the death certifics by the attending pt ached for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	1		23	ld. Date of delive Month	ry Day Year
r r	Se de de	by	Part II. Other significant conditions con-	tributing to death but r	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use		e cause of death?
al Kecords	The law ate has b page 2 st	Completed									sy findings available apletion of cause of
VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatie	ot 3 DOA Oth	er: 4 Nursing H			Other (Specify	1
ion or	ing Phy n. After this funeral d	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		f 28c. Injur	y at	28d. Describe h)
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st 'Specify)	reet, factory, office		28f. Location (S City or Tox		Number or Rural	Route Number,
	Hospi 24 hou Funer Hely fill	edical	29a. Certifier	ician: To the best of re: On the basis of exand manner states	camination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as sta lace, and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	0		29c. Licens				signed (Month, L	
	~		Ma 2/20	lld t	MIDUSTI	G DS6	399	1	Lone	is, 200	S
İ	0		30. Name and address of person who con	mpleted cause of deat	th (Item 23a) (Type,	Print) ST.	BALTI	REORS			
	sta Registr		31. Date filed Month, Cay Year 005		Signature						

			For State Registrar	State of Ma	-	partment of lertificate of		ind Me	-	giene	05	20188
I	Physicia		1. Decedent's Name (First, Middle, Las Inez	it)	Mc	Laurin			Date of Dea Month	Day	Year	3. Time of Death 12:18 P M
	/Medic Examin		4a. Facility Name (If not institution, give Union Memorial H			4b. City, Town, o			<u>a one</u>	4c. Count	y of Death	10.73
	Funeral Director		217-24-0973	C CTV-	9 (In yrs. last birtho 75 Yr	Months Davs		Min. 8	Date of Birth (Month, Day 5-15	(, Year)	9. Birth	olace (State or Foreign ontry) Md -
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Harforo		10c. City, Town o	r Location orest Hill						10d. Inside City Limits
	or 28a-	Director	10e. Street and Number			10f. Zip Code				10g. Citizen of	What Cou	ntry?
	ath w	rai	306 Streett Cir				.050	ing /Canai	h. Van ar Na	US	A ce - Ameri	nan Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "netural; or Itema 23a or 28a-f show other traumatic event, Ita Madical Examinal must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		3. Was Decedent of lif Yes, specify Cut		gin <i>r</i> (Specii , Puerto Ric	ean, etc.)	Bla	ack, White, f_y : $B1a$	etc.
Maryland 21215-0036	"nature	Completed by	15. Decedent's Ed (Specify only highest gra		(0	ecedent's Usual Occu live kind of work done ie. DO NOT use retire	during most	of working		16b. Kind of E	3usiness/Ir	dustry
212	e filed within al Hygiene. I other than "	Comp	Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5	+)	etitian	,			Union		Hosp.
land	should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) John		kins		_	r's Name (/ ena	First, Middle,	Maiden Suma Lyn	•	
lary	2 shoul and Me is mark		19a. Informant's Name/Relationship (ailing Address (Stree						
	1 and Health am 27 ther tr		Ronald McLaurin 20a. Method of Disposition	Son	20b. Place of D	38 Normal sposition (Name of	Ť	Balti		Md. 20c. Location	21218 - City or T	
Mor	Pages ient of nt: if it ry or c		N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		1	crematory or other pla Mem. Pk.		6-20-	-05	Randal	lstow	m. Mđ.
Baltimore,	permit. Pages 'Dep rtment of P Important: if its any injury or of ones.		21. Signature of Funeral Service Licer	w on	رے	22. Name and Addr March F.	ess of Facility	у	Balt		Md,.	21202
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one ca <i>u</i> se on each lir a	the death. Do no ne. Show a consequence of	enter the mode of dy	ing, such as	cardiac or r	espiratory an	rest,		Approximate Interval Between Onset and Death
\ \ \ \	exacuted hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last	b. Previous Due to (or as	a consequence of							4 days
x 68760,	death certificate be e rattending physiciar d for use as the buria	edicai	IF FEMALE:	d23c. If yes, outcome	of pregnancy					23d D	ate of deliv	90/
P.O. Box	at the death of by the atten- tached for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су				lonth	Day Year
	as the gned	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	ne <i>u</i> nderlying cause g	ven in Part I.		23e. Did to	_	atribute to t	he cause of death? bably 4 JUnknown
Vital Records,	و غ و	Completed							24a. Was autop perfor	an 24b sy rmed? 2 No	. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			th an		Check only o			
of	Phys this ral dia	on: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Tir	ne of 28c. Injury	ary at ork?	28		dence 6 00 now injury occu		fy)
Division	r Atten ter deat irector: by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farn c. (Specify)	M 1 [Yes 2 1		f. Location (5 City or Tow		nber or Rur	al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exal	nysician: To the best niner: On the basis of and manner sta	of my knowledge, f examination and/ ated.	death occurred at the or investigation, in my	time, date an opinion, deal	d place, an th occurred	d due to the d at the time, d	cause(s) and n date and place	nanner as s , and due i	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licer	ise number			29d. Date sign	ed (Month,	Day, Year)
	/		1 000	vis, MD		ATO	2438	946		June	14,	2005
	5		30. Name and address of person who Wisha Dawis M 31. Date filed (Month, Day, Year)	D Union	leath (Item 23a) (T Memoric ar's Signature	29c. Licer AT ppe, Print) L Hospi Ha	el E	Baltu	nore,	MD	212	218
	Sta Regist		11N 1 7	ZUUD Rieve	w H	Goarde)						

			1- State of Maryland / Department of Health and M Certificate of Death		iene) () 5	20189
			Decedent's Name (First, Middle, Last)	2. Date of Deati	h	3. Time of Death
	Physici /Medic		DOROTHY MOROZ	JUNE 1	5,2005 Year	7:55 a ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	1
			EASTPOINT REHAB & NURSING CENTER BALTIMORE		BALT	
	Funeral Director		5. Social Security Number 220-03-0245 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 24 Hrs. 1 Months 24 Hrs. 1 Months 24 Hrs. 1 Months 24 Hrs. 1 Months 24 Hrs. 24 Hrs. 25 Min.	8. Date of Birth (Month, Day, AUG. 2	9. Birth (28, 1921 M	nplace (State or Foreign Intry) ARYLAND
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla f sho	o	MD. BALTIMORE BALTIMORE			1 □ Yes 2 XNo
	the 286-	Funerai Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	intry?
	3a or	Ē	1046 OLD NORTH POINT RD. 21222		U.S.A.	
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Amei	ican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show any injury or other treumetic event, I'm Medical Evariliner must be notified at once.	y Fu	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2☒ No Specify:	rican, etc.)	Black, White	
21215-0036	hours ture!	d by	3 (Awidowed 4 Divorced Year or Dates:		WI	HITE
5	in 72 "n" re	olete	(Specify only highest grade completed) (Give kind of work done during most of work)	ing	16b. Kind of Business/I	ndustry
212	y with	Completed	Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE		DOMEST	C
	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
Jaï	uld b Ments arked	ToE	FRANK MOCEK UNKNO	OWN		
Maryland	2 sho and lis ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			<i>'</i>
	and lealth m 27		DONALD MOROZ/ SON 122 S. HIGHLAND AVE			
0	ges 1 It of H If ite or oth		1 Burial 2 MCremation 3 Bemoval from State cemetery, crematory or other place)		20c. Location - City or 1	
Baltimore,	t. Pa ntmen rtent: njury		`4 Donation 5 Other (Specify) BAYVIEW CREMATORY 6/16		ALTIMORE,	
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER 700 S. CONKLING	NC. FU STREET	NERAL HON ,BALTIMOR	ME RE,MD.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between
	Physician	i. 15	Immediate Cause (Final disease or condition ATHEROSCLERO TIC CARI	DIOVAS	ZOV LAR	Onset and Death
	/Medical Examiner		resulting in death) Due to (or s a consequence of):	DISE	AE	
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
4	ted nsit	Examiner	Cause (Disease or injury	ER	Ų.	
	execunand and all-tra	Exai	that initiated events resulting in death) Last Due to (or as a consequence of):			
38760,	icate be executed physician and s the burial-transit	edicai	MALNIOTRI ECON			
_						
Вох	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	•
0	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify)		Month	Day Year
Δ.	that I	уРЬ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	quires n sign	d by	DEPRESSION	1 □ Ye	s 2 No 3 Pro	bably 4 Dunknown
000	sw require s been sign	Completed		24a. Was ar	24b. Were aut	opsy findings available ompletion of cause of
æ	sicien: The law certificate has t irector, page 2 s	mo		autopsy perform 1 Yes 2	y prior to c ned? death? !☑No 1 ☐ Yes	ompletion of cause of
ta	ien: rtifica stor, p	ø	25. Was case referred to medical 26. Place of Death			242110
_	nysic nis ce direc	To B	examiner? 1 Yes 2 No	me 5 Reside	nce 6 □Other (Spec	ify)
0	ding Phys n. After this funeral di		1 (Matural 5 Pending (Month, Day Year) Injury Work?	28d. Describe ho	w injury occurred	
Sio	tendi leath. tor: A the fu	cati	2 Accident investigation M 1 Yes 212No			
Division of Vital	l or Atteno after death Director:	Certification;	4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Ru , State)	ral Houte Number,
_	spite lours nerei		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ate and place, and due	to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier 29c. License number	29	ed. Date signed (Month	Day, Year)
	1		Sevensulitally 40 02/188	t	115/05	
	Market and Company		30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)	No o	Ma 112	2155
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	Klina	elic rip.	21222
	Sta Registr	_				
			JUN 1 6 2005 Frank			

			For State Registrar	State of Maryland		artment of rtificate o		lental F	lygien Reg. N	UU	5 6	2019	30
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Month		ay =	Year	3. Time of	_
	/Medic		BORIS			NUDELMA		JUNE				2:40	Ам
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Towr	n, or Location of Death BALTIMO	DE	4	lc. County of		IMORE	
	Eurovol	- 2	#6 RUSSERN COURT	7. Age (In yrs. I	ast birthday)	If Under 1 Ye		8 Date of	Birth				or Foreian
п	Funeral Director			^{M 2□ F} 73		Months Da	ys Hours Min.	MAR.	Dav. Yea	932	Cour	lace (State d itry) JKRAIN	E
	D >		Usual Residence of Decedent 10a. State 10b. County	100 Cin	, Town or Lo								
	fanyla show	ŏ									'	0d. Inside C	2 √ No
	28e-1	Director	10e. Street and Number	IMORE	DALI	IMORE	е		10g. C	Citizen of W	hat Cour		
	3a or		#6 RUSSERN COURT,	APT. 1-A			21215					USA	
	deatl	Funeral		2. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or	No-		- Americ	an Indian,	
36	or the	by Fu	1 Never Married 2 Married	1 □ Yes 2 💢 No If Yes, Give		1 ☐ Yes 2 ∑ 1		, , , , , ,		Specify:		WHIT	F
8	72 hours after death with the Maryland Insturat; or Items 23a or 28e-f show Jical Exactinatives be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Oc			16h	Kind of Bu	siness/In		
15	n "na	plet	(Specify only highest grade	completed)	(Give		ne during most of work	ing	100.	Talla of Ba.	31110334111	austry	
212	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	COBE	LER			SH	IOE RE	PAIR		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Mid			a)		
Уa	should be Ind Mental I	ဥ	SAMUEL	7.0		LMAN	LIZA		UNKN			0.13	
Maryland 21215-0036	A1 (0 or et	li	19a. Informant's Name/Relationship (Typ. RIVA NUDELMAN /			-	eet and Number or Run COURT, APT.					Code) ID 2121	15
	Health tem 27 other tra		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	-	Location - (
E G	Pages nent of I ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	natory`or other CEMETE		/2005	ΩW	ITNGS	MTII	S, MD	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License				dress of Facility SO						
<u> </u>	88 58		KSUTO/C	Show >	8	900 REI	STERSTOWN	ROAD -	PIK	ESVIL	LE,	MD 212	208
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death e cause on each line.	n. Do not ent	er the mode of o	dying, such as cardiac	or respirator	y arrest,			Approximat Interval Bet Onset and I	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Lung		ace	R					Onook and	Jount
	/Medical Examiner		Toolaing in about,	Due to (or as a consequ		u Sis	11/						
	-	e	Sequentially list conditions, if any, leading to immediate	Due to (o as a consequ	· (he eeee.				1				-
	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	CKION	100	28st	Zucliv	e 6	u	12"	10-5	5.	
oʻ	rate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):								
8760,	the the	dlcal	d.	-							-		
9	leath certific attending p	/Me	IF FEMALE:	Sc. If yes, outcome of pregnat	ncv					22d Date	of dalive		
Вох	atten affor u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3	Ectopic pregna Other (specify				23d. Date Mon		*	Year
0	t the de by the tached	hysi	9 Unknown	9□ Unknown									
s, P	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as	ру Р	Part II. Other significant conditions con	tributing to death but not resu	ılting in the u	nderlying cause	given in Part I.	23e. D	id tobacco			e cause of o	
ord	w require been sig should t	ted							Yes	2 No	3 🗌 Prob	ably 4 □l	Jnknown
Record	e law r has be je 2 sh	Completed						24a. W	itopsv	DI	rior to co	psy findings apletion of c	
al H								1 □ Ye	erformed? s 2	lo 1	eath?	2□No	
Vital	Physicien: this certificated ral director,) Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	FD/0		26. Place of Deat			a 🗆 au	10		
of		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	I 3L DOA	4 Nursing no	28d. Descri	esidence be how inj			′)	
ion	Attending death. ctur: Afte y the fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Work? □Yes 2□No						
Division	I or Atter after des Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, offi	се	28f. Locatio City or	n (Street a Town, Sta	and Numbe	r or Rura	l Route Num	ber,
	urs aff ral Di												
	To the Hospital or Atlending within 24 hours after death. To the Funbral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	n occurred at the vestigation, in m	e time, date and place, ny opinion, death occur	and due to t red at the tin	he cause(ie, date a	(s) and mar nd place, a	ner as si nd due to	ated. the cause(s	;)
	o the	Med	29b. Signature and title of certified	and marrier states.		29c. Lic	ense number		29d. D	ate signed	(Month,	Day, Year)	
	F S F O		If fol	2202		0	005471	16	1	06/1	570	5	
	2		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	Print)		~					
	0		Br. A. POKOV - 68	npleted cause of death (Item 2 1 Purstern 32. Registrar's Signal	tow	n ld i	#200, B	alfo,	ms	0 21	215		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	12							
	ricgisti	-EII	JOIN T (5002	fred the state of	1								

				partment of Health and Meartificate of Death		ene . N. 005	20191				
	Physici	an	1. Decedent's Name (First, Middle, Last) Charles Edward O'Bryon		2. Date of Death	, Day 2005 Year	3. Time of Death 9:25 AM M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Julie 12	4c. County of Death					
			Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Frederick V) If Under 1 Year If Under 24 Hrs.	2 Data of Righ	Frederick					
	Funeral Director		220-26-2375 X M 2 F 86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Youne 2,	1919 Kans	lace (State or Foreign htry) AS				
	yland Nor		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			1	0d. Inside City Limits				
	Ba-f sl	Director	Maryland Frederick Freder				1 ☐ Yes 2 No				
	h with t	ai Dir	1606 Rock Creek Drive	10f. Zip Code 21702	10g	. Citizen of What Cour	itry?				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at anone.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Yas 2 No If Yes, Give W II Year or Dates:	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto P	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.				
Maryland 21215-0036	within 72 ho lene. r than "natur the Medical.	Completed	(Specify only highest grade completed) (Girling (1-40r 5+)	edent's Usual Occupation No kind of work done during most of working DO NOT use retired) mical Engineer	ng	b. Kind of Business/Ind US Governm	·				
land	ild be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) Calvin Floyd O'Bryon	18. Mother's Name Esther	(First, Middle, Mai						
Mary	12 shou h and N 7 Is mai traumai	_		iling Address (Street and Number or Rural 8 Little Magothy Vi							
	of Healt of Healt item 2		20a. Method of Disposition 20b. Place of Dis			c. Location - City or To					
altimore,	t. Pages rtment of i rtant: If it		`4 □ Donation 5 □ Other (Specify) Smithsburg	Crematory June 14, 2	005 S	mithsburg,	Maryland				
Ba	Depa Impo any ii		21. Signature of Funeral Service Licensee M00255	22. Name and Address of Facility Keeney and Basford 106 East Church St	PA Fune:	ral Home	21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.											
ä	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequency of):	werkerd tof	ende	u	1 haven				
Ĭ,	Examiner	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
8760,	rate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):								
9	rtificate ng phys as the	Medic	IF FEMALE:								
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	B □Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ny Day Year				
ords, P.	w requires that been signed k should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	cco use contribute to th	e cause of death?				
Vital Records,		Completed			24a. Was an autopsy performed 1 ☐ Yes 2/1	d? prior to cor	osy findings available inpletion of cause of				
	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ▼ FV/Outpati	ent 3 DOA Cther: 4 Nursing Hom		a 6 Dothar (Specif	4				
n of	ding Phy h. After this funeral c	⊢	27. Manner of Death 1 ☑Matural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 2. Work?	8d. Describe how i		9				
Division	tand leath tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office 2	8t. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,				
	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)				
	To the within 2	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, I	_				
	n		30. Name and address of person who completed cause of death (Item 23a) (Typi	# 100796 a, Print)		ne 13, 200					
	0		Francis 6. Benker MP) 300	1 W. GTAST	reden	ch, Md	21701				
	Sta Registr		31. Date filed Worth Day, 2day 5								

			1 - State Registrar Amend Item 1. Decedent's Name (First, Middle, La:		Per F	и с844	tificate	0/05	Death	and M	2. Date of De.	ath 🖺	. UUU	(2) (3) Time (of Death.
	Physici /Medio		Lily A. Okura								June 1	4, Day	2005 Year	183	5 M
	Examir		4a Facility Name (If not institution, give	e street and number	er)		4b. City,	Town, or	Location o	of Death		4c.	County of Dea	th	
			5 303 Friendship	Court			Beth	_		0411			lontgome		
	Funeral Director		5. Social Security Number 6. S 564-09-3738	ex ☐ M 2 💢 F	Age (In yrs. i 86		If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da Jan. 2	$\stackrel{\text{th}}{0}, \stackrel{\text{Year}}{0}, 1$	Co	thplace (State ountry)	
	- 6		Usual Residence of Decedent								Jan. 2	0, 1	JIJ Ca	Liforni	.a
	arylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside (•
:	286-13	ecto	Maryland Montgom	ery	Bet	hesda	T								s 2 X No
	death with the Maryland ms 23a or 28e-f show r nutt be notified at	Funeral Director	10e. Street and Number 6303				10f. Zip					-	izen of What Co	-	
	ms 23	era	5303 Friendship C	12. Was Decede			Was Deced	817 ent of Hi	spanic Orig	gin? (Spe	cify Yes or No		ted Sta		
	after or ite	Fur	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 f			f Yes, sp <i>ec</i> 1 □ Yes 2			, Puerto I	Rican, etc.)	İ	Black, Whit	e, etc.	
21215-0036	72 hours after naturel', or ite ileal Evanine	d by	3X Widowed 4 □ Divorced	Year or Date	s:								Specify: As	sian	
15-	"nati	Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	I Occupa k done a e retired	ition <i>luring m</i> ost I	of workii	ng	16b. K	ind of Business	/Industry	
212	yiene. r then "	mo	Elementary/Secondary (0-12)	College (1-40	or 5+)	Manag						Cor	porate/	Non-Pr	ofit
	12 should be filed within and Mental Hygiene. 7 le marked other then ". raumatic event, the Men.	Bec	17. Father's Name (First, Middle, Last)								(First, Middle,		_		
yla	ould by Ment warked warked warked	To	Sadao T. Arikawa								M. Mor				
Maryland	12 sh hand 7 le m traum		19a. Informant's Name/Relationship (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1							r Town, State, 2		2011
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. In Important: If from 27 is marked other then "naturel", or items 23a or 28e-f show any Injury or other traumatic event, Ira Medical Examinating the notified and once.		Mays A. Nakashima 20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	e of					s, Vir		2066
ō E	Pages ent of nt: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Sta	we Met	emetery, crer ropol: matory	itan	her place	3) J	une 2005		Δ1 as	xandria	Virmi	nia
Baltimore,	permit. I Departm Importar any Injui		21. Signeture of Funeral Service Licet	-	CLE	nia LOI V	. Name and	d Addres			ert A.	Pumj	phrey Fo	uneral	Home/
8	88 58		Blind	Levy	_ M00	803 Be	thesd	a-Cr	ievy ([aryla	nase and	20814-	$\frac{755}{3501}$	7 Wisco	nsin A	venue
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	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)		osche	rotio	Ci	ard	ioua	SCU	lar o	101	edse	yedi	
	Examiner			Due to (or	as a consequ	uence of);								/	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (cr.	قة مُ درياة ، و ر	ال عدادة									
♥ .	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
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687	ificate g phys	edicai		d											
Xo	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			Ectopic pre	апапсу					23d. Date of del	ivery	
		sicis	in the past 12 months?	4 Pregnant	at time of de		Other (spe						Month	Day	Year
P.0	res that the de signed by the a i be detached f		9 ☐ Unknowh Part II. Other significant conditions c			ulting in the u	nderhijna ca	ulee awe	n in Part I		23e Did to	phacco I	ise contribute to	the cause of	death?
ecords,	iaw requires that the as been signed by th 2 should be detache	Q	Tarrii. Othor organicani conditions	onthibuting to doub	T Dut Hot 1630	nang in the di	idenying ca	1030 9140	iiiiiraiti.		1 🗆 Y	4	No 3□Pr		Unknown
COL	w require been signal	lete									24a. Was	an	24b. Were au	itopsy findings	available
m ;	icien: The fav certificate has rector, page 2	Completed									autop	sy med?	prior to death?	completion of o	cause of
	rtifical	Be C	25. Was case referred to medical						26. Place	of Death	(Check only o	2)(No ne)	1 🗆 Yes	2 1 No	-
of V	rnysicien: this certific ral director.	ToE	examiner? 1 Ves 2 □ No	Hospital: 1 ☐ Inpa		ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 □ Nu	rsing Hon	ne 5 resid	ence (3 □Other (Spe	cify)	
		iuo]	27. Manner of Death 1 Natural 5 ☐ Pending		njury Day Year)	28b. Time of Injury		Bc. Injury Work	?		8d. Describe h	ow injur	y occurred		
Division	death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		Injury - At ho	me farm str	M eet factory		′es 2⊡1		28f Location /S	treet an	d Number or Ru	ra I Route Num	nher
Div	after after Directory	Certification:	4 Homicide determined	building,	etc. (Specify)	soi, laciory,	Onice			City or Tow	m, State)	man route run	1001,
	lo the Hospitel of Atending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the be niner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a	at the tim in my op	e, date and inion, deat	d place, a h occurre	and due to the o	ause(s) date and	and manner as place, and due	stated. to the cause(s	s)
	o the o the omple	Med	29b. Signature and itle of certifier	and manner	n Z	1, 1	29c.	License	number			29d. Dat	e signed (Monti	h, Day, Year)	
) '	.6		· lotucia	lomas	Re 7.	lay, "	EC	D5	19/1	8_		Ju	ne 14)	2005	7
	12		30. Name and address of person who	Nay III	death (Item	23a) (Type,	Print) / //2 /	Pike	2, 6	-100	2 Rock	Luil	1/e, MI	0 208	52
	Sta Registr		31. Date filed (Month, Day, Year)	2005 Regi	trar's Signat	ture	hade	1		7			,		

9		1 - State Registrar Amend It 1. Decedent's Name (First, Middle	ems 23a,25, em 22 per 1	naryland 27,28a FH,G84	d/Depa a-f. pe 4,06/	artmen F: ME 7/050	t of H C84 4 ThB	bealth a	and M 10/0	Tental H	Reg. No.	005	2 () 3. Tin	Q 3
Physici /Medi		Helen	Parker							May 18	3, 200)5	6	:30AM ^M
Examir		4a. Facility Name (If not institution	-	or)				Location				County of De	ath	
		College Mano 5. Social Security Number		Age (In yrs. Ia	ast hirthday)	If Under		rvill If Under	_	9 Data of B		Baltimo		
Funeral Director		214-46-2483 Usual Residence of Decedent	1□M 2ਊF	99	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, L 3/29/	1906 1906	M	ARYLAN	ate or Foreign
with the Maryland e or 28a-f show be notified at	tor	10a. State 10b. County	IMORE		r, Town or Lo	cation		-						de City Limits Yes 2 🕅 No
ath with the 23e or 28a	I Director	10e. Street and Number 1000 E. JOPPA	ROAD APT.	204		10f. Zip	Code 1286	5				zen of What	Country?	
ltems	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Force ied 1 \(\subseteq Yes, \(\text{Give} \) Year or Dates	s?] No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	10-	I4. Race - Ar Black, WI Specify:	nite, etc.	n,
hin 72 hour 3. 3n "neturel Medical Ex	Completed	15. Deceden (Specify only highe. Elementary/Secondary (0-12)	t's Education at grade completed) College (1-4o	r 5.L)	16a. Deced (Give life.	ient's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ation luring mos.	t of work	ing		nd of Busines		
d 2 should be filed within 72 hours all th and Mental Hygiens 17 is marked other then "neturel; or treumetic event, Ita Medical Exert		12TH_GRADE		1 3+7	OPER	ATOR							COMMU	NICATIO
2 should be fi and Mental H is marked ot eumetic ever	To Be	17. Father's Name (First, Middle, BACOMB SAULSE						MAF	RGARI	e (First, Middl ET TRAN	/ERS			
C - 14 F		19a. Informant's Name/Relations CHERYL CONROY/N				g Address Cast				arlingt				
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		е	ace of Dispo metery, crer ELAND	natory or of	her place	´		Date 0/2005		cation - City of		е
permit. Page Department of Importent: If eny injury or		21. Signatur of Funeral Service HOTHUR 23a. Flatt. Enter the disease, or shock, or heart failure. List	Licensee	,	22	The an	olini	on Fa	mer.	A HOTE	Bu Pu	ck, 85		h ₄ Raver
cate be executed by sician and the burial-transit	al Examiner	Sequentially list conditions, any lear ing 1 imma data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	s a consequi	ence dil):				CERTIFIC	ATON XPPHON	ED BY MEDI	CAL EXAMINE	H	0
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ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Doath	(Check only		- 1016	2 2 2 1 1 1 0	
Phys r this ral dii	on: To	1 ★ es 2 No 27. Mann Death 5 Pendin	Hospital: 1 Inpat		R/Outpatien 28b. Time of Injury		Othe Sc. Injury Work	4 Nui	-	ne 5 Res 28d. Describe			ecify)	
for Attending after death. Director: After	catle	Accident investig	02/21/	2005	Unkno	wn ^M	1 🗆 Y	es 2 X		Subjec				
를 를 들는 다	Certification:	4 Homicide determ	ned 28e. Place of It building, & At ho	me					1	.000 Е.	Jopp	a Rd.	<i>#</i> 204	,
To the Hospitel within 24 hours a To the Funeral I completely filled	edical	one) 2 Medical	g Physician: To the bes Examiner: On the basis and manner s	of examination	rledge, death on and/or inv	occurred a estigation,	t the time in my op	e, date and inion, deat	d place, a h occurre	and due to the ed at the time.	cause(s) a date and p	ind manner a place, and du	s stated TO	wson, MD
To To com	Σ	29b. Signature and title of certifier	(Lase	ulit	regh	40	License D2	number 4/2	/		29d. Date	signed (Mor	oth, Day, Yea	r)
3)		BRUCE RO	who completed cause of SENBER	6	1/21	Print)	57	25	7	0.030	N	MO:	2120	f
Sta Registr		31. Date filed (Month, Day, Year) JUN 1	2005 32. egis	trar's Signat	A So	we								

			1 - For Stata Registrar	State of M		ertificate of		Mental Hygie	ne 005	20194
	Physic /Medi		1. Decedent's Name (First, Middle, Las. MARY PAR	,				2. Date of Death Month	Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give				or Location of Deal	1	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birthday 48 Yrs.		ar If Under 24 Hrs			thplace (State or Foreign country) Maryland
	death with the Maryland ms 23e or 28a-f show	Director	10a. State 10b. County Maryland Baltimo 10e. Street and Number	re	10c. City, Town or L		3	100	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r death with ems 23e or	Funeral Di	2520 Pot Spring R	oad 12. Was Decedent Armed Forces?	Ever in U.S. 13	210			United St	ates encan Indian,
9600-	hours after tural', or Its	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No	1□ Yes 2☐XN	lo Specify:			Black
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Maryland	outd be file Mental Hy wrkad othe	To Be (17. Father's Name (First, Middle, Last) unknow				Mary		iden Sumame)	Parker
ore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28a-f show any injury or other traumatic event, the Madical Examinal must be notified at ance.		19a. Informant's Name/Relationship (T) Kathy Yetz (frien 20a. Method of Disposition 1□ Burial 2 XCremation 3□F	d)	2520 20b. Place of Disp	Pot Spr	ing Road,	Timonium, Date 200		93
Baltimore,	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Brian T.	2. Name and Add Chishol	m Funeral	, 2005 Ba Services ad, Timoni	of Dulane	ey Valley PA
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)	To t With To t	¥	29b. Signature and title of certifier Why Hays	lon	MD	Do	nse number 06282(1	Date signed (Month	
	Va		30. Name and address of person who co	ANGELO	4 22 50	ATH GR	EENE ST.	BALTIN	ORE m	0 21201
41	Sta Registr		31. Date filed (Month, Day, Year) 7 2	005 32. Rigistra	r's Signature	Joseph				

			1 - For Stata Registrar	State of M	laryland		artmen rtificate				/lental H	ygien Reg. N	2 U U		201	95
	Physic	an	1. Dacedent's Name (First, Middle, Las	t)							2. Date of I	Da	ay Y	(ear	3. Time of	
	/Medi	cal	HYMAN 4a. Facility Name (If not institution, give				POTL				JUNE	15,	2005		8:00	Αм
	Examir	ner	FUTURE CARE CHEI		,		46. City,	lown, or	RFT:		STOWN	40	c. County of R.A	Death LTIN	IORE	
	Funeral		Social Security Number	9x 7. Ag	ge (In yrs. las	t birthday)	If Under		If Under	24 Hrs.	8. Date of I	Birth			ace (State o	r Foreign
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	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							10	d. Inside Cit	ty Limits
	Man e-fsh	tor	MD BALT	TIMORE		BALT	IMORE								1 ☐ Yes	2 X No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wh	at Count	ry?	
	s 23a	ra	29 MARY CARROLL						2120						USA	
' 0	hours after death with the Maryland tural', or Items 23a or 28e-f show I Executive Livest by Indiffed at	Funeral	11. Marital Status 1 □ Never Married 2 🛣 Married	12. Was Decedent Armed Forces?	?	13.	Was Deced If Yes, spec	ent of History	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or I Rican, etc.)	No-	14. Race - Black,	America White, e		
036	ral', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	110		1□Yes 2	No X	Specify:				Specify:		WHITE	i
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121	within 72 ene. then "net	ldmo	Elementary/Secondary (0-12)	College (1-4or	5+)	OWNE	DO NOT us	e retired)				FOO	חו			
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Ħ	permit. Pa Depurtmen Important: any injury		21. Signature of Funeral Service Licens		BEIH						L LEVI	NCON	WOODL			
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each li	d the death. [Do not ente	er the mode	of dying	, such as	cardiac o	or respiratory	arrest,	Interval Betw			veen
	Pnysician	W Y	Immediate Cause (Final disease or condition resulting in death)	a. Pnew	monio	L								d	Onset and D なりよ	eath
	/Medical Examiner		Tosuming in death)	Due to (or as	a consequen	ce of):										
	0.5	jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a Ansequen	ce of):								LU	Cons	
٧	cuted nd ransit	Examiner	that initiated events	c. Cereb	ro vasc	ular	- ac	cide	nts					4	ears	
50,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequen	ce of):										
68760,	physicate to physicate the k	edical		d												
Вох	The law requires that the death certific ten has been signed by the attending page 2 should be detached for use as s	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy								23d. Date <i>o</i>	f deliver	,	
m m	that the death	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spe					1.0	Month			еаг
P. 0	that the ed by ti detach	Phy	9 Unknown													
Vital Records,	signe d be d	d by	Part II. Other significant conditions co	antiouring to death o	ut not resultin	ig in the un	ideriying ca	use giver	n in Part I.			Yes 2	use contribu	ite to the Dr <i>o</i> bat		ath? nknown
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Be	The lay	Completed									aut	opsy formed?	prio dea	r to comp th?	pletion of car	use of
		BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes (Check only	-		Yes 2	□ No	
	Physic this ce al dire	P	1 □ Yes 2 WNo	lospital:			3 DO	-	4 Jay INU		me 5□Res			Specify)		
uc	ding Phy h. After thi funeral	tlon;	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	y Year) 28t	b. Time of Injury	28 M	Work			28d. Describe	how inju	y occurred			
Division of	teat tor: the	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home,	, farm, stre			es 2 🗆 f	-	28f. Location	(Street an	d Number o	or Rurai F	Route Numb	er.
ā	tal or s afte el Dire ed in t	Cert	4 Homicide determined	building, etc	c. (Specify)		, , , , , , , , , , , , , , , , , , , ,					wn, State				,
	To the Hospital or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Madical Exami	sician: To the best of	of my knowled	dge, death	occurred a	t the time	e, date and	d place, a	and due to the	cause(s)	and manne	er as stat	ed.	
	thin 2 the or the implet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.			License		·	od at the time					
)	F ≱ F 8		1 Na 0-0-		me	0	_		587	14			te signed (N			
	n		30. Name and address of person who co	ompleted cause of d	eath (Item 23a	a) (Typa. F		3	- 0 1			June	2/3		03	
	13		D Roggen	5400 018	Court	Rd 3	re 108	Ro	odail.	5100	in mo	_ 21	133			
	Sta Registra		31. Date filed (Month, Day, Year) JUN 1 7 2005	32. Registra	ar's Signature	Lack	1)									
			AOM T L FOOD	R. W. W. S. S.	55	The same of										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Herma M. Reid 11:30 PM 2005 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner HARFORD BELAIR LORIEN Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) July 15, 1913 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 216-44-9596 1 ☐ M 2 🕮 F Yrs Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Heelih end Mental Hygiene.
Important: If Item 27 is marked other than "natural" or the say injury or other traumetic event. 10a, State 10c. City, Town or Location 10d. Inside City Limits Bel Air 1 ☐ Yes 2 ☐ No Harford Director 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? Funeral 21014 U.S.A. 511 Barkeford Road 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 2 Married white 1 ☐ Yes 2 Ho Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 years traffic clerk U.S. government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Ann Stuart John McGee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 Barkeford Road, Bel Air, Md. 21014 Betty Reid/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 6/14/2005 Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA ENDSTAGE Examiner Due to (or as e consequence of) Physician/Medical Examiner or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of ettending physician end Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DYSPHAGIA RECURRENT PNEUMONIA Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? COROWARY ARTERY DISEASE 1 Tes 1 □ Yes 2 □ No FIBRILLATION ATRIAL To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifici completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dev. Yeer) Tucklarken D45344 30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 10 41) 622 S. UNION
32. Begistrar's Signeture AVE, HAVRE DE GRACE, MD 21018 40 SURESH DHANJANI 2005 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mary		artment o rtificate			Reg. No. 2 0 0	5 20197
	Physic /Medi	cal.	1. Decedent's Name (First, Middle, Las Auscoe P.	Rogers				2. Date of De Month	13 200	5 11-4317M
	Exami	ner	49 Facility Name (If not institution, give 5. Social Security Number 6. Se	lare H	ospital yrs. last birthday)	R 5		rs. 8. Date of Bir	4c. County of De	Birthplace (State or Foreign Country)
	Director		246-22-1628 10 Usual Residence of Decedent	3 M 2□F	78 Yrs.	Months Da	lys Hours Mi	Feb. 2	4,1927No	cthCarolina
	Marylan 9-f show	tor	MD 10b. County Baltim	i i	Esse					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	3a or 28	Funeral Director	10e. Street and Number 510 N. Marlyn	Ave.		10f. Zip Cod	221		10g. Citizen of What	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show amportants of items 23a or 28e-f show any injury or other treumetic event. The Medical Examples must be multiply at ance.	by	11, Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:			of Hispanic Origin? Duban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)		·
Maryland 21215-003	filed within 72 ho Hygiene. Ither then "natur ent, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th	cation de completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re chinis	one during most of w tired)	orking	16b. Kind of Busines Western	Electric
ryland	2 should be filled withir and Mental Hygiene. is marked other then eumetic event, the Me	To Be C	17. Father's Name (First, Middle, Last) Jasper C. Roge				Laura	R. Stee		
e, Mai	1 and 2 st Health and Iem 27 is n		19a. Informant's Name/Relationship (T) Thelma Rogers 20a. Method of Disposition	/wife		N.MAr	lyn Ave.			
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of ence.		1 ☐ Surial 2 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation 3 ☐ Cremation	Removal from State	akWood	natory or other Cemete	ry 6,	18/05	Statesvi	lle NC
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Licens	1 Conne		300 M	<u>ace Ave.</u>	Baltin	nore MD 2	meofEssex
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	identions that caused the cause on each line. Due to (or as a con		er the mode of o	dying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,		dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con		*				
O. Box 6	death certifi e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal déath 3	Ectopic pregna			23d. Date of d Month	elivery Day Year
rds, P.	signed signed d be de	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause	given in Part I.		obacco use contribute ⁄es 2□No 3□F	
Vital Record	The ate ha	Completed							an 24b. Were a prior to death? 2 No 1 Ye	
of	ing Phys After this uneral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Ir	Oth o-		ne) dence 6 Other (Sp now injury occurred	ecify)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, streecify)	et, factory, office	Ce Ce	28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
	Fo the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the estigation, in m	time, date and place y opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
)	To the h within 24	M	29b. Signature and title of certifier	South	MID	, Re	solo o o o		29d. Date signed (Mon	5
	Sta Registr	_	30. Name and address of person who confirm to months of the filed (Mg/TN) Day, Mar 2005	mpleted cause of eath (i	anklin	Print) 59U	ore DI	rive B	Saltimo	(P MD 2/23)

			1 - For State Registrar	State of M	larylan		artment <i>rtificate</i>			and M		giene	105	20198
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Och Aa. Facility Name (If not institution,)		4b. City, T	/ (c	Location o	f Death	2. Date of Dea Month	Day	2005	3. Time of Death /720 PM
	Examin	ier	The Linus Ho	OKING H	asati	aL	Bas	Lt	Morse	e C	Lu	40.00	N A	
	Funeral Director		5. Social Security Number 219–40–1773 Usual Residence of Decedent	5. Sex 7. A	ge (In yrs. i	last birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth Month, Day 11-5-	, Year)		place (State or Foreign htry) Md.
	yland how		10a. State 10b. County		10c. City	y, Town or Lo	cation	·					1	0d. Inside City Limits
	8e-f s	Director	Md.	NA		Bal	timore	•						1 X Yes 2 ☐ No
	with the	Die	10e. Street and Number 2200 Homewood A	WO			10f. Zip C		2			l0g. Citizer	of What Cour	ntry?
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V		1218		in? (Spe	ecify Yes or No-	14.	USA Race - Americ	can Indian.
21215-0036	72 hours after death with the Maryland haturel, or Items 23e or 28e-f show dical Examiner must be notified at	þ	1X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 24 If Yes, Give Year or Dates:			f Yes, specif 1 □ Yes 🛚 💥		Specify:	Puèrto	ecify Yes or No- Rican, etc.)		Black, White,	
15-("natu	ietec	15. Decedent's (Specify only highest	Education grade completed)		(Give	ient's Usual kind of work	done di	iring most	of worki	ng	16b. Kind	of Business/Inc	dustry
212	d within 72 hours agiene. er then "naturel", c	Completed	Elementary/Secondary (0-12) 10th grade	College (1-4or	5+)		oo NOT use Jsekee					л н	Univer	caitr
	⊕ 子 美 美	BeC	17. Father's Name (First, Middle, L.	ast)		110	مان مان	-		r's Name	(First, Middle,			sity
ylaı		ToE	John	W.	F	lamlet					rnia		Rice	
Maryland	12 s har 7 is		19a. Informant's Name/Relationshi Lynn Hopkins	р (Турө, Print) Nie							/ Route Number		wn, State, Zip	
Baltimore,	es 1 an of Heal if item 2 or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3	3 □Removal from State	20b. P	lace of Dispo emetery, cren	sition (Name natory or oth	of er place		D	sville,	20c. Locat	Apt.	wn, State
altin			 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li 		MU	. Carn	. Name and		of Facility		1-05 Baltin		alk, Mo	
ñ	permit. Departr Importe any inji		> Glad	Ma. 2 rth Ave	21202									
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Il Records,		Completed									24a. Was ar autops perform 1 🗆 Yes 2	۷ ـــ ا	prior to con death?	sy findings available apletion of cause of
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		1 - For State Registrar	State of Ma	ıryland		artmer <i>rtificat</i>			and M		giene Reg. No	$\cup \cup \cup$	5	20199
		Decedent's Name (First, Middle, Last)							2. Date of De				3. Time of Death
Physicia /Medic		Waldo Watson Simo	ons							Month 06	Da 11	200	fear 5	05:15p ^M
Examin	er,	4a. Facility Name (If not institution, give						Location o			40	County o		
		Collington Nursi						ellvi.				Prin	ce (George
Funeral Director		5. Social Security Number 081-32-1276A Usuel Residence of Decedent		85	ast birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt	h <u>/_ 1º3()</u> 	19	9. Birthi	place (State or Foreign
aryland show	_	10a. State 10b. County	7		, Town or Lo						-			10d. Inside City Limits
8a-f	Director		seorge	MI	tchell									1 ☐ Yes 2 🔀 No
th with t		10e. Street and Number 10450 Lottsford 1				10f. Zip	Code	207	21		_	izen of Wh JSA	at Cou	ntry?
be filed within 72 hours after death with the Maryland trait Hygiene. all Hygiene. do other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates:	ver in U.S io 193	3 13.	Was Deced If Yes, spe- 1 ☐ Yes	37	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-		White,	
ad within 72 hours aff giene. er than "natural", or ', the Madical Exem	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)		+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa rk done d se retired,	ition luring most	of worki	ng	16b. K	ind of Bus	ness/In	dustry
e filed within al Hygiene. other than vent, the Ma	5		4+		Ship	buil	der					US N	avy	
nd 2 should be filed lith and Mental Hygis 27 is marked other r traumatic event,	To Be (17. Father's Name (First, Middle, Last) William Butterfie	eld Simons	•						(First, Middle, Waldo	Maiden	Sumame		
to, mary last and year theatth and Men Item 27 is marke other traumatic.		19a. Informant's Name/Relationship (7) Harriet Simons (v			19b. Mailir 1045	og Address O Lot	(Street a	nd Numbe	r or Rura	Route Numbe	r, City o	r Town, S	ate, Zip 11e	MD 20721
permit. Pages 1 an Department of Heal important: if item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Ce	ace of Dispo metery, cren esapea	natory or o	ther place			7-2005		cation - C	•	own, State
permit. Departmitimporta		21. Signature of Funeral Service Licens		0038	F	lapp]	Funer	s of Facility	Cre	nation r Sprin	Serv	ices	10	
		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of				er the mod	e of dying	g, such as o	cardiac o	r respiratory an	rest,	203		Approximate
Physician		Immediate Cause (Final disease or condition			ve Hea									Interval Between Onset and Death
/Medical		resulting in death)	Due to (or as a			IL F	ııııı						-	
Examiner		Sequentially list conditions	Arte	rios	cleros	is								3 months
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Line following Cause (Disease or injury that initiated events	Due to (or as a	consequ	ence of):									
sxecuter and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of);				-					
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death cert e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal	death 3	Ectopic pr Other (sp					2	23d. Date Month		ary Day Year
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i or Attending after death. Director; Afte d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At hon (Specify)	ne, farm, stre			es 2□N		8f. Location (S City or Tow	treet and n. State,	d Number)	or Rura	l Route Number,
	Medical Ce	29a. Certifier 15 Certifying Physic (Check only one) 2 Medicel Exemi	sicien: To the best of ner: On the basis of	examinatio	rledge, death on and/or inv	occurred restigation,	at the time	e, date and inion, death	place, a	nd due to the c	ause(s) late and	and mann place, and	er as st	ated. the cause(s)
thin ; the c the mple	Mec	29b. Signature and title of certifier	and manner state	ed.			License							Day, Year)
F 3 F 8		· K. Dak	heel	ne	· D.	250		02649	92	2		-15-2		
10		30. Name and address of person who co Riad Dakheel 4000) Mitchell	ville	e Rd.	B216	Bowi	e MD.	207	716				
Stat Registra		31. Date filed (Month, Day, Year) 7	2005 ^{32. Redistrar}	r's Signatu	ILO Y	perk	1							

				artment of Health and Me	ntal Hygiei	george of the same wind									
	Physici		1. Decedent's Name (First, Middle, Last)	2	. Date of Death	3. Time of Death									
	/Medic		Mary Patricia Sutton	,		11, 2005 2:16 A M									
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Bel Air		4c. County of Death									
	Funeral		301 Hemingway Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		. Date of Birth	Harford 9 Birthplace (State or Foreign									
	Director		216-30-5271 1□M 2♥F 70 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yes	ar) 9. Birthplace (State or Foreign Country) MaryLand									
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li												
	Aaryla f sho	ō		Bel Air		10d. Inside City Limits 1X Yes 2 □ No									
	the N	Director	10e. Street and Number	10f. Zip Code	100.	Citizen of What Country?									
	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show diest Executat be rediffed at		301 Hemingway Drive	21014	1.03.	U.S.A.									
	ams ams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 13.	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - American Indian, Black, White, etc.									
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 No Specify:	July 5(6.)	Specify: White									
Ö	hour			dent's Usual Occupation	165	Kind of Business/Industry									
215	hin 72 In "ng Medik	plet	(Specify only highest grade completed) (Give Elementary/Secondary (0·12) College (1·4or 5+)	kind of work done during most of working DO NOT use retired)	100.	And or business/industry									
21	od wit gjene er the	Completed	12th Grade Com	outer Operator	C	itibank									
nd	be fill	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F											
Maryland 21215-0036	hould d Mer marks matic	은	Joseph Ambrose 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Mary EL											
	nd 2 stith an 27 is r trau			N. Shamrock Road, Be											
Je,	s 1 a of Hea itam othe		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date matory or other place)		Location - City or Town, State									
<u>Ë</u>	Page nent c				/05 Hy	les, Maryland									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or Items 23e or 28e-f show any injury or other traumatic avant, Tra Medical Ever it er roust be rediffed at ORGS.		St. John the Evangelist 6/16/05 Hydes, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air, MD 21014												
	= 4		23a. Fart1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between									
	Prrysician	Immediate Cause (Final disease or condition The TASTATIL BRAST CONEZ 1													
	/Medical Examiner		Due to (or as a consequence of):												
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.												
0	ate be executed hysician and the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):												
8760,	cate be executed bhysician and the burial-transit	Physician/Medical	d.												
9	death certifica e attending plad for use as t	/Me	IF FEMALE: 23b. Was decoded program: 23c. If yes, outcome of pregnancy	-		20d Date of delivery									
Вох	death a atter d for u	Iclar	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year									
P.O.	that the death	hys	9 ☐ Unknown												
Ś	gne	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?									
ord	w requir been si should I	ted			1 Yes	2 No 3 Probably 4 Unknown									
3ec	e taw has b je 2 si	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?									
a		e Co	25. Was case referred to medical		1□ Yes 2XN	lo 1 Yes 2 No									
5	yaiclen: The t is certificate ha director, page	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Cont. 3 DOA Other: 4 Nursing Home		6 ☐Other (Specify)									
סר		T in	27. Manner of Death 28a. Date of Injury 28b. Time of		. Describe how inj										
Sio	ttandir death. stor: Al	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No											
Division of Vital Record	l or Attanding after death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)									
_	Hospital		29a. Certifier Certifying Physician: To the best of my knowledge, death	Occurred at the time, date and place, and	due to the cause/	s) and manner as clated									
	To the Mospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)									
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)									
	1		In Timber	118320		4/13/05									
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,			E M2 21093									
	⊕ Stat	e		FALLS RA. LUT	क्षर ११०१८	6 .17 410)?									
	Registra		31. Date filed (Month, Day, Year) JUN 1 7 2005 32. Figistrar's Signature	المان											

			1 = For State Registrar	State of Ma	iryland / Dep <i>Ce</i>	artment of I <i>rtificate of</i>			giene 005	20201					
	Physic	an	1. Decedent's Name (First, Middle, Li	ist)				2. Date of De	ath	3. Time of Death					
	/Medi		Thomas			chec	h	June	Day Year	- 11:414 M					
	Exami	ier	4a. Facility Name (If not institution, gi	Pec 11	/:/	4b. City, Town,	or Location of Death	h A Y	4c. County of Dea	ath					
	Funeral		5. Social Security Number 6.	Sex 7 Age	(In yrs. last birthday)	If Under 1 Year	MORE If Under 24 Hrs.	B Date of Birt	h o Bi	45-1					
	Director			1 ∑ M 2□F	70 Yrs.	Months Days	Hours Min.	April I	4, 1935 Ma	thplace (State or Foreign ountry) Tyland					
	pur		Usual Residence of Decedent		100 City T										
	lanyta ehov	20	10a. State 10b. County MD Balt	imore	10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
	the A	Director	10e. Street and Number	- Imore	Darcin	10f. Zip Code			10- 0::						
	d within 72 hours after death with the Maryland giene. Ir then "neturel", or items 23e or 28a-f ehow The Medical Examinational be mailited at		2826 E. Balti	more Stre	eet	2122	24		10g. Citizen of What Ci USA	ountry?					
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of I	Hispanic Origin? (Spean, Mexican, Puero	pecify Yes or No-							
36	s afte	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N	0	1 □ Yes 2√√ No		o mean, etc.)	Black, Whi						
21215-0036	2 hour		15. Decedent's E	Year or Dates:		dent's Usual Occup									
215	within 72 ene. then "net	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	(Give	kind of work done DO NOT use retire	during most of world)		16b, Kind of Business	Andustry					
	filed wit Hygiene ther the	Com		1yr	Mec	chanial	Enginee	r	Steel						
ınd	be filed ital Hygie od other event, L	Be	17. Father's Name (First, Middle, Last						Maiden Sumame)						
Maryland	should band Ments of marked	ဥ	George Scheo		200 100 100			Grief							
Ma	and 2 sho salth and n 27 ie m	1	19a. Informant's Name/Relationship (MaryJaneSchec						r, City or Town, State, Baltimor						
ē,	s 1 ar if Hea item		20a. Method of Disposition	<u></u>	20h Place of Dispo	sition (Name of	1	Date							
<u><u>E</u></u>	Pages nent of ent: If it		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		SacredH	natory or other place eartofJ	esus 6/	16/05							
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked other eny injury or other treumatic event, DDCs.		21. Signature of Funeral Service Lice	19/e	7/ 22	2. Name and Addre	ess of Facility	nnellvī	'unoral Hor	moofEass.					
	707 • 0		M. Terry	Connel	4	300 M	ace Ave.	. Balti	more MD						
Н	Marille.		shock, or heart failure. List only	a. Part1. Enter the disease, or complications that caused the doa'h. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Approximate Interval Between											
	/Medical	H													
Н	Examiner				consequence on:										
	D ==	ner	Sequentially list conditions, if any cause. Enter Underlying	Due to (or as a	nonsacjuence of/										
	ecuted and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					yFuneralHomeofEssex timore MD 21221 ry arrest, Approximate Interval Between						
60,	tificate be executed Ig physician and as the burial-transit	al E	Tosailing in obality East	Due to (or as a	consequence of):										
68760,	ficate phys s the	edical		d						<u> </u>					
Box	eath certifii attending p for use as	D/M€	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy				23d. Date of deli	ivery					
	es that the death cer igned by the attendir be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti]Ectopic pregnancy] Other <i>(specify)</i>	/		Month	Day Year					
P. O.	at the	Phys	9 Unknown	9□ Unknown				-							
	The law requires that the death cer te has been signed by the attendir page 2 should be detached for use		Part II. Other significant conditions of		not resulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to						
Ö	w requir been si should	eted	Hypertensio		2/0-			1 U Y	es 2 No 3 Pro	obably 4 Z Unknown					
Records,	has b	Completed by	HYPERCHOL	ester.	of emic	2		24a. Was a autops perforr	v prior to c	topsy findings available completion of cause of					
-		e Co	25. Was case referred to medical					1 ☐ Yes	No 1 Yes	2 No					
>	Physiclen; r this certific ral director,	0 8	examiner?	Hospital:	2 ER/Outpatien	Oth	er:								
ס ר	4 - E	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Worl			ence 6 Other (Spec	city)					
Sign	Attendir death. ctor: Af y the fur	atlc	1 Natural 5 Pending 2 Accident investigation	1	rea <i>r)</i> Injury		Yes 2□No								
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,					
_	e Hospitei 24 hours a e Funerei I letely filled		29a. Certifier 1 X Certifying Ph	veicing: To the best of	my knowledge, death	and the si									
	e Hospitel 124 hours i e Funerel letely filled	edical	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xammation and/or my	estigation, in my of	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1 0	29c. License	e number	2	9d. Date signed (Month	, Day, Year)					
	d	П	- J'MLION	MRC	man	NO D	0058	917/1	JUNE 11), 2005					
1	2		30. Name and address of person who	completed cause of lea		Print)	I want al	7 55 (-	74.	UE MD 21287					
	C		31. Date filed (Month, Day, Year)	32 Aegistrar	G (M)	2 6001	JOH H WE	rre st	MITMO	UE IND 41281					
:	Stat Registra	-	JUN 1 7 2	105 Shewe	A April	all y									

				opartment of Health and			
		1 - For Amend Item 8 Registrar	&10d&Unpend Item 2	epartment of Health and Sa. pt. II. 27 per me Certificate of Death 6-	1 Mental Hygie 2 6844 -30-05 tas	ne 005	20202
Dhysia	ion	Decedent's Name (First, Middle, Las	1)		2. Date of Death		3. Time of Death
Physic /Medi		ANTHONY S	Sienkiekus	Ki	June 15,	2005	2:21 P M
Exami	ner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De	eath	4c. County of Death	
C Furzonal		Mercy Hospital 5. Social Security Number 6. So	ex / 7. Age (In yrs. last birth	Baltimore If Under 1 Year If Under 24 H	IS. R Date of Righ	0 8:4	
Funeral Director			The other in	rs. Months Days Hours M			place (State or Foreign intry)
P .		Usual Residence of Decedent 10a, State 10b, County	10.00			rnc	rylaria
the Marylar 28e-f show	ō	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
the A	rect	10e. Street and Number	More	10f. Zip Code	100	. Citizen of What Cou	No
1215-0036 within 72 hours after death with the Maryland ane. then "neturel", or Items 23e or 28e-1 show the Maryland Exercite and the Americal Exercite at the Americal Exercite at the Americal Exercite at the American Exe	Funeral Director	1675 Yakon	2 Rd.	21286	109.	UCA	ii iu y :
r deaf	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ameri	
36 s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 M Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	ento riican, etc.)	Specify: / A)	, etc.
21215-0036 d within 72 hours aft giene. Then "neturel; or the Medical Exert	ed b	15. Decedent's Ed	Year or Dates:			W	ire
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212 ad with giene er the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	lectrician		LOCAL	24
be filed trial Hygind of other event, I	Be	17. Father's Name (First, Middle, Last)	1/1- 2011	18. Mother's N	ame (First, Middle, Mai	den Sumame)	
faryland 212. 2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental the mental the	2	ramon BO	1enhiewski_	Ame	lia S.	Serio)
Maryland d 2 should be file th and Mental Hy. 7 is marked oth treumatic event		19a. Informant's Name/Relationship (7	ype, Print) 19b. N	Mailing Address (Street and Number or	Rural Route Number, C	ity or Town, State, Zij	Code)
re, N s 1 and s f Health item 27		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date: 200	Location - City or To	own State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-1 show any injury or other treamatic event, the Marical Engineers is necessarily once.		1 Marial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Heliloval Itom State	crematory or other place)	20/05 11	millou	O MD
Baltimo permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	10000	22. Name and Address of Ficility	vans char	zel of me	mones
m %3 E & 8		I from I IV	Som	8800 Harford 12.	Parwille,	np 2123	4
		SHOCK, OF HEART TAILUTE. LIST OFFING	lications that caused the death. Do no ne cause on each line.	t enter the mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a Acute thrombosis	of right coronary	artery		Onset and Death
Examiner			Due to (or as a consequence of)	:			
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ocuted nd fransif	Examiner	Cause (Disease or injury that initiated events	с				
3760, Ife be executed sysician and ne burial-fransit		resulting in death) Last	Due to (or as a consequence of)	:			
2 2 2 2	dical		d				
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Box 68 death certifica e attending ph	Physiclan/Med	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver	ory Day Year
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IS, Free that igned be def	by	Part II. Other significant conditions co Previous myocardia		ne underlying cause given in Part I.		o use contribute to the	ne cause of death?
Cord w require been si	eted	TICVIOUS My Ocur uit	ir intarctions		1 🗆 Yes	2 No 3 Prob	ably 4 Minknown
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be continued.	Completed				24a. Was an autopsy	prior to cor	psy findings available npletion of cause of
		25. Was case referred to medical			performed		2 No
	o Be	axaminar?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	0.1	eath (Check only one)	1 Tour 10	
on of ding Phy.	h:u	27. Manner of Death	28a. Date of Injury 28b. Tim	ne of 28c. Injury at	Home 5 Residence		/)
Vision Attending r death. sctor: Affer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju	M Work? M 1 □ Yes 2 □ No		and the same	
Division of or attending Phy after death. Director: After this in by the tuneral d	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rura ate)	l Route Number,
pitel o		Con Continue 45 Continue Div					
24 ho 24 ho 3 Fun etely 1	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, d ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and placer investigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
Divisio To the Hospitel or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and tipe of centifier	A A	29c. License number	29d. (Date signed (Month, I	Day, Year)
. , , , ,		> XV (da	/ VV	OCME		ne 16, 200	
		30. Name and address of person who co	om leted cause of death (Item 23a) (Ty	pe, Print)111 Penn Stree		re, Maryla	
		5.K. 1706	7/1/			,	21201
Sta Registra		31. Date filed (Month, Day, Year)	37 Registrar's Signature	barle			

			For State Registrar	State o	f Mary	land / De		nt of H	lealth :	and M	lental Hy		enn (5	20203
	Dharain		1. Decedent's Name (First, Middle								2. Date of D Month			Year	3. Time of Death
	Physici /Medi		Kenneth Robe	ert Smit	h						06/1	5/2	005	Teal	7:45 P ^M
	Examir		4a. Fecility Name (If not institution		mber)		4b. City	Town, o	r Location	of Death			. County o		
			Gilchrist Ho					son		0411			alti		
	Funeral Director		5. Social Security Number 215-28-0491 Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	7. Age (In	yrs. last birthda 4 Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of B	19 (19)	30	9. Birthp Coun Mar	lace (State or Foreign try) yland
	laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Items 23a or 28e-f show sumatic evant, the Medical Evantinar must be nutified at	or	10a. State 10b. County Maryland Balt	imore		c. City, Town or								1	0d. Inside City Limits
	288-	Funeral Director	10e. Street and Number			000110		p Code				10g. Cit	izen of Wh	nat Coun	try?
	h with	ā	6112 Moorefie	eld Road			21	228				Uni	ted	Sta	tes
	deatl	ner	11. Marital Status	12. Was Deci	edent Ever	in U.S. 13				igin? (Spe	ecify Yes or N Rican, etc.)		14. Race	- Americ	an Indian,
	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryls Health and Martlat Hyglene. Itiam 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic evant, the Medical Experimer must be notified at	ρ	1 Never Married 2 Marri 3 Widowed 4 Divorced		2 No		1 ☐ Yes	. 6	Specify:		nicari, etc.)		Specify:	, White, Wh	ite
	5-0 72 ho	Completed	15. Decedent (Specify only highes	's Education		16a. Dec	edent's Usu	al Occup	ation	t of work	'na	16b. K	ind of Bus	iness/Inc	lustry
	ithin ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of wo DO NOT L		-	SE OF WORK	ng .				
	led w lygler her th		7	1 - 3		Pap	er Ha	inge			(m)				ovement
	and The findat Hed out	Be	17. Father's Name (First, Middle, William Smith								(First, Middle		Sumame)	
•	ryli hould d Me mark matic	2	19a. Informant's Name/Relationsl			19h Ma	ilina Addres	s (Straat			Porter		v Tour S	tate Zin	Code
	≥ n∈⊳≥		Frances E. Sm		ife		_								21228
	Baltimore, IM permit. Pages 1 and 2 Department of Health Important: If itam 27 1 any injury or other tre once.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	State 20	Ob. Place of Dis cemetery, ci	oosition (Na ematory or	me of other plac	се)	06/2	eate 20/05	20c. Lo	ocation - C	ity or To	wn, State
:	Baltin permit. Pa Departmer Important any injury		* 4 ☐ Donation 5 ☐ Other (S)		1	Loudon			1		Zuno no				Maryland
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	Physician		23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	each line.	- Dr	AGE				or respiratory	arrest,			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a cor	nsequence of):	, ,	-							0
87	/ Po #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
V	8760, sate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a cor	nsequence of):									
10	\$8760 icate be e physician s the buris	cai		d										-	
1945	Box 68 leath certific attending p	an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out			□Ectopic p	regnancy	,			1	23d. Date		
0)	ti the dea by the at tached fo	Physici	1 Pes 2 No 9 Unknown	4□Pregr 9□Unkn	ant at time own		Other (s)						Monti	n 	Day Year
10	ecords, P. law requires that as been signed b 2 should be deta	b	Part II. Other significant condition	ns contributing to d	eath but no	t resulting in the	underlying (cause giv	en in Part I	l.					e cause of death? ably 4 Unknown
9	± 4 € 8	ompleted	<u> </u>								perf	opsy ormad?	pri de	or to con ath?	osy findings available appletion of cause of
£ :		e Co	25. Was case referred to medical						26 Place	e of Death	1 Check only		1	Yes	2 No
2	09 (7)	To B	examiner? 1 ☐ Yes 2XZNo	Hospital:	npatient	2 ER/Outpati	ent 3 D	Oth Oth			me 5□Res		6 Y Other	(Specify	Hospice
2		Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date (Mon.	of Injury th, Day Yea	28b. Time	of	28c. Injun Wor			28d. Describe		y occurred	1	,
7	VISION Attanding r death. actor: After	atic	2 ☐ Accident investig	gation			М		Yes 2□	No					
imith, Kenneth	2 p 8 2 2	Certificatio	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	inod 200. Flave	of Injury - ng, etc. (S)	At home, farm, soecify)	treet, factor	y, office				(Street an own, State		or Rurai	Route Number,
Smi	2 4 7 7	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the Examiner: On the b	best of my asis of exame ner stated.	knowledge, de mination and/or	ath occurred investigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s) , date and	and mans splace, an	ner as sta d due to	ated. the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	my li	Cer,	ans	29	c. Licens	e number	5		29d. Dat	te signed (Month, L	Day, Year)
	6		30. Name and address of person	who completed cau	death	(Item 23a) (Typ	e, Print)	Parl	es St	1	welts	in	121	20/	k
	Sta		Barry and		egistrar's S	Signature	,								
	Registi	aı	JUN 1 7	2005	aur.	J. A.	and I								

			1 - For State Registrar Amend Item	State of M #20c Per	laryland / [Inf G844	Departo Certific	5785°51 cate of L	ealth a Death	and Me		giene Reg. No.	A 63 63 63 6	20201			
	Physic	ian	Decedent's Name (First, Middle, Last)	Rita A.	Suffredi	ni			2	. Date of Dea	ath Day	/ Veer	3. Time of Death			
	/Medi Examir		4a. Facility Name (If not institution, give				City, Town, or	Location of	of Death	June		County of Dea	11:00 A M			
			6 Rice Court				Rockvi1					ontgome				
	Funeral		5. Social Security Number 6. Security Number 163-03-9619	7. A	ge (In yrs. last bin		Under 1 Year Inths Days	If Under Hours	24 Hrs. 8 Min.	Date of Birti (Month, Day	, Year)	9. Bir	thplace (State or Foreign ountry) nsylvania			
	Director		Usual Residence of Decedent		96	115.			S	ept. 2	1, 19	908 Pen:	nsylvania			
	ryland	_	10a. State 10b. County		10c. City, Town	or Location	n						10d. Inside City Limits			
	Ba-f s	Director	Maryland Montgome	ry			ckville						1 X Yes 2 □ No			
	with t		10e. Street and Number 6 Rice Court			10	of. Zip Code 208	50		1	_	zen of What Co ed Stat				
	death	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was [Decedent of His , specify Cubar		gin? (Specif			14. Race - Ame	erican Indian,			
36	or its	by Fu	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	No		s, specify Cubar ∕es 2∭ No	Specify:		can, etc.)		Black, White Specify: Wh				
9	hours!	ed b	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:			Usual Occupa					nd of Business				
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23s or 28s-1 show he Mazical Exir. iner: sust be notified at	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or		(Give kind o	of work done di OT use retired)	urina most	t of working		160. Kii	IIO OI BUSIIIOSS	moustry			
21	ygien ygien yar tha	Con		3		Organ:				Church						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Maxical Exercities instituted at once.	Be C	17. Father's Name (First, Middle, Last) Gino Nocentini							ne (First, Middle, Maiden Sumame) .a Tomasello						
aryl	should ind Me i mark umatio	2	19a. Informant's Name/Relationship (Ty	pe, Print)	19b.	Mailing Add	dress (Street a					r Town, State, 2	Zip Code)			
Ž,	and 2 salth a n 27 ls		Michael Suffredini	/Son												
Baltimore,	ges 1 t of He If itan or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	comotor	Disposition y, crematory	(Name of y or other place) :			20c. Lo	cation · City or Canaan,	Connecticut			
Ħ	it. Pa intmen intant: njury		* 4 □ Donation 5 □ Other (Specify)	Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State New Canaan, Connecticut												
Ba	Depar Impo		1 Ry Jus		M00198	200 M	est Mon	rgome	ry Ave	e., Koc	KAIT	e/Rockv 1e, MD	ille, Inc. 20850-2805			
	Physician		Immediate Cause (Final disease or condition	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and enterval Between Onset and Death of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death of the disease												
	/Medical Examiner		resulting in death)		Inferio		1. 1	T C			Interval Batween Onset and Death Minutes					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):	cardial	Inia	rctio	n	Ganaan, Gonnecticut al Home/Rockville, Inc. ockville, MD 20850-2805 y arrest, Approximate Interval Between Onset and Death							
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examin	that initiated events													
8760,	be exe ician a burial-	al Ex	resulting in death) Last	Due to (or as	a consequence o	of):										
687	ficate physical physi	edical	\ 0													
Вох	eath certific attending p	M/ue	230. Was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Fetal death	3 TEctor	pic pregnancy				2	3d. Date of deli	very			
Ю. П	at the dea by the att tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	4□Pregnant a 9□Unknown			er (specify)					Month	Day Year			
٩	that the		Part II. Other significant conditions con	tributing to death t	out not resulting in	the underly	ring cause giver	n in Part I.		23e. Did tol	pacco us	se contribute to	the cause of death?			
Vital Records,	quires an sign uld be	ed by	Renal Insufficier	ncy						1 □ Ye	s 2.⊠	SNo 3□Pr	obably 4 Unknown			
eco	law requas been 2 shoul	24a. Was an 24b. Were autopsy findings ava									topsy findings available completion of cause of					
		g d U 1 Yes 2KJNo 1 LIYes 2 L														
Σ. Eξ	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	ent 2 ER/Out		Other			heck only on						
		-	1 ☐ Yes 2 🖾 No 17	28c. Injury	at Nur		5 🔀 Reside I. Describe ho		Other (Spec	uty)						
Sior	Attending I r death. ector: After by the funer	catio	1 XNatural 5 Pending 2 Accident investigation	(Month, Da	ty roary in	jury M	Work? 1 □ Y	es 2 🗆 N	No							
5	II or Attend after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	jury - At home, fan tc. <i>(Specify)</i>	m, street, fa	actory, office		28f.	Location (St City or Town	reet and n, State)	Number or Ru	ral Route Number,			
1	To the Hospital or At within 24 hours after or To tha Funeral Direct completely filled in by		29a. Certifier 1⊠ Certifying Phys	icien: To the best	of my knowledge.	edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						stated				
	the Ho in 24 h tha Fu npletely	ledical	(Check only 2 Medical Examinone)	er: On the basis of and manner st	of examination and	Vor investiga	ation, in my opi	nion, deat	h occurred a	at the time, d	ate and	place, and due	to the cause(s)			
	To the within 2.	Σ	29b. Signature and title of certifier				29c. License					signed (Month				
,	7		1 6 046	-our			D405	0/0			June	15, 20	005			
	20		30. Name and address of person who con R. Oskoui, M.D. 3	mpleted cause of d 301 New_			N.W., W	lashi	ngton.	D.C.	20	016				
	Sta Registr		31. Date filed (Month, Day Year) 1 7		rar's Signature											

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)		•	State of Maryland / D State Amend Item 1&Unpend Item 23a, p	epartment of Health and Certificate of Death	Mental Hygi 6-30-05	ene 2. 2005 20205			
			1. Decedent's Name (First, Middle, Last) Frederick Fay T		2. Date of Death	3. Time of Death			
	Physici		Frederic F.	haver	June 13	, ^{Дау} 005 ^{Year} 0131 А. м			
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital	4b. Oity, Town, or Location of Deat Baltimore	h	4c. County of Death			
9	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birt) Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) 9. Birthplace (State or Foreign Country) 3(c MARYLAND			
Λ	e Maryland la-f show	Director	10a. State 10b. County 10c. City, Town BALTIMORE 10c. City, Town	Or Location RALTIMORE		10d. Inside City Limits 1 ⊡ Yes 2 (174)o			
	th with th	ai Dire	3200 Texas Ave.	10f. Zip Code 21234	10	ng. Citizen of What Country?			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23e or 28a-f show eny injury or other treumatic event, It w Modical Examiner must be invitited at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Myes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Whi H.			
21215-0036	within 72 ho ene. then "natur ne Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking				
Maryland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Benjamin F. Thauer	18. Mother's Nar	me (First, Middle, M				
	and 2 sho ealth and n 27 le m		Shirley Thayer 36	106 Texas Ave.	Baltim	Dre MD 21234			
Baltimore,	Pages 1 ment of H ent: If ited ury or oth		20a. Method of Disposifion 20b. Place of cemeters 4 Donation 5 Other (Specify) 20b. Place of cemeters 20c. Place	Disposition (Name of y, crematory or other place) Victorial (Popel - 10 - 10)		E VV. 1 CO.			
Balt	permit. Departr Importe eny inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility.	MORE, M	16b. Kind of Business/Industry BALTIMORE (6) It, Middle, Maiden Surname) Lydard 16 Number, City or Town, State, Zip Code) 11 No. 10 2123 V 20c. Location - City or Town, State CE, MD 2123 V PEL STO HARFORD RO- piratory arrest, Approximate Interval Between Onset and Death 23d. Date of delivery			
	Physician		23a. Part1. Enter the disease, or complications that ceuted the death. Don shock, or heart failure. List only one cause to each line. Immediate Cause (Final disease or condition Atherosclerotic	ot enter the mode of dying, such as cardiac cardiovascular dis		st, Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a consequence of						
	cuted and and and and and and and and and an	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events	f):					
8760,	cate be executed physician and the burial-transit	dicai	resulting in death) Last Due to (or as a consequence of d.	f):					
P.O. Box 6	Attending Phyeicien: The law requires that the death certific rideath. •ctor: After this certificate has been signed by the attending Eby the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown 1 Unknown Unkn	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year			
	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions contributing to death but not resulting in Chronic alcoholism		acco use contribute to the cause of death?				
Division of Vital Records,	icien: The law racentificate has be ector, page 2 sh	Comple			24a. Was an autopsy perform 12 Yes 2	prior to completion of cause of			
=======================================	yelclen: is certific director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Out	ath (Check only one				
of	Phye this al dir	2	TENOUT			nce 6 Other (Specify)			
n C	Jing F	ion	Terratulal Self-ording	ime of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred			
Divisio	or Attendiater death. Director: A	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)			
1	Hospital 4 hours a Funerel ely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place Vor investigation, in my opinion, death occu	a, and due to the cau urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)			
	⊢ <i>5</i> ⊢ ŏ		Theodoll, Hand may	OCME		une 13, 2005			
			30. Name and address of person who completed cause of death (Item 23a) (1 01001			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		et Baltir	more, Maryland 21201			
	Registi	ar	JUN 1 7 2005 June 15.	14 12 200					

ORIGINAL

Rlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Shelby Turner 05-03984 1 - For State Registrar NJM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Shelby Turner М 2005 1600 June 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 219-11-2279 1 □ M 2 👽 F 33 YES. Director 9 - 30 - 71Md Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10h Counts 10d. Inside City Limits 28a-f show "neturel", or Items 23a or 28a-f shov dical Examiner sust be notified at Md. NA Director 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 E. 32nd Street 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No à Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ith and Mental Hygiene.

27 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) llth grade Laborer Various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental Hi fitem 27 Is marked off rother treumetic even Be 2 Arthur Turner Sharon Eames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Turner Father 1802 E. 32nd. Street, Baltimore, Md. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of Hi Important: If iter any injury or oth 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 6-27-05 Dundalk, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 & e 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Narcottic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. physician IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ Subdural Henorrhage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \(\subseteq \) No certificate has autopsy performed' 1 X Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Certification: To 1 XYes 2 No Prod Date of Injury Prod b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending death. 6/10/2005 3:10 P M investigation 1 ☐ Yes 2 X No after death 2 Accident unk 6 XCould not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number City or Town, State) filled in by 4 - Homicide found at residence Baltimore, Maryland 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 0 OCME June, 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland 21201 State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 13, Day 2005 **Physician** 12:40 a M Frances Lynn Vorsteg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days 1 M 2 F 214-78-5710 Yrs. Dec. 18. 1957 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State ral', or Itams 23a or 28a-f show 1 Yes 2 XNo Harford Edgewood Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 604 Rivershore Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 257 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) bank teller 12 years banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank W. Tyler Dolores E. Weaver 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 604 Rivershore Court, Edgewood, Md. 21040 Robert J. Vorsteg/husband Department of Health Important: If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2005 Bayview Crematory Baltimore, Md. 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) leans Physician CANCER OU AVI AN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier un 30. Name and address of person who impleted causs of death (Item 23a) (Type, Print) N. Charle St. Rolto Md 21208 6-Binc 6701 31. Date filed (Month) 32. gistrar's Signature State 2005 Registrar

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Registrar

JUN 1

425-45

State of Maryland / Department of Health and Mental Hygiene 🛭 🗍 💍 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 2-10-10 RC 13 05 6047 AM /Medical 4a. Facility Name (ir not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OF NOSPITAL DALTIMORE BALTIMORE MD mas 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 27 **Funeral** Birthplace (State or Foreign
Country) Days 1 M 20 F Hours Year) 64 Director 219-38-6731 40 MD Usual Residence of Decedent death with the Maryland 10a State 10b. Count 10c. City, Town or Location Item 27 is marked othar than "natural; or items 23a or 28e-f show other traumatic evant, the Medical Examinator must be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes XXNo Baltimore Randallstown 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5701 Old Court Road 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked othar than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2♥ No Specify: Black Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) llth grade Clerical Credit Card Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ William Palmer Josephine Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Wallace Jr.-Son 3703 Lamoine Road, Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 6/20/05 Owings Mills, Md 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Choma yea /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitel or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. igned by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate has 1 Yes 2 No 2□ No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of After Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number rence Vor Law DMON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solonon Lawrence 1838 Mp 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For	State of Mar	•			ental Hygier	enns	20210
			1 - State Registrar		Cei	tificate of L		Reg.	No.	L. U.L. TO
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	and *		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
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and	be filed tal Hygid d other event, II	Be (17. Father's Name (First, Middle, Last)	10-00			18. Mother's Name (First, Middle, Maid	len Sumame)	
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<u>a</u> a	2 E E		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rural	Route Number, Cit	y or Town, State,	Zip Code)
IPs.	s 1 and 2 of Health Item 27 other tr		20a. Method of Disposition	LKEKIOH	20b. Place of Dispo	sition (Name of	KIPOE KI	te 20c.	Location - City or	Town, State
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	Vithi To the	Σ	29b. Signature and title of certifier	DIRE		29c. License	100	29d. I	Date signed (Moni	
			PKOSS C. DOVENOWE		CAL ONCOLL				6.15.0))
	7		30. Name and address of person who a	completed cause of dea	th (Item 23a) (Type, ONNS Ho put s Signature	MS Hospit	ol Ra	House	. WD Z	1231
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature				,	
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			1 - For State Registrar	State of Maryland	I / Departmer	nt of Health and te of Death	-	ne 005	20211
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	Funeral Director		SOUTHERN MA 5. Social Security Number 217-20-9817 Usual Residence of Decedent		st birthday) If Under	1 Year If Under 24 Hrs Days Hours Min		PG1 9. Birth 9. Con 9. Con	pplace (State or Foreign intry) Carolin
	or death with the Maryland tems 23a or 28a-f show at must be realified at	Irector	10a. State 10b. County Ad P. G. 10e. Street and Number	10c. City,	Town or Location inton 10f. Zip) Code	10g.	Citizen of What Cou	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
5-0036	after or Ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Tho If Yes, Give Year or Dates:		20735 dent of Hispanic Origin? (s crity Cuban, Mexican, Puer 25 No Specify:		14. Race - Ameri Black, White	ican Indian.
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Ball	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licens auf fun C 23a. Part. Enter the disease, or company and authority follows:	Dondan	22. Name and 1701	d Address Pracility (a) McCulloh e of dving, such as cardia	St. Ballo	Ad. 21.	e.e. 134. 217 Approximate
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_	7	127	30. Name and address of person who co	,MD 750	Ba) (Type, Print)	atts Roc			
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State of Maryland / Department of Health and Mental Hygiene

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	/Medi Examir				give street and numb	er)		4b. City, Town, or Location of Death			may 2	-	4c. County of Death		
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	Director		579-28-7 Usual Residence		1□M 2 F	78	Yrs.	Months Days	Hours	s Min.	8. Date of Bi (Month, Di 07/21/	ау, Yea 192		place (State or Foreign intry) ington, DC	
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ē,	Health Thealth Item 27		20a. Method of Dis	sposition		20b. PI	lace of Dispo	sition (Name of			ate		Location - City or T		
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5	ysician: is certific director,	0	examiner? 1 ☐ Yes 2 🏋		Hospital: 1 X Inna	itient 2 🗆 E	B/Outnation	3 □ DOA Cthe			(Check only a		C [] ()		
o	Attending Physician: r death. sctor: After this certific by the funeral director.	L ii	27. Manner of Dear		28a. Date of Ir (Month, L		28b. Time of	28c. Injury	/ at		Bd. Describe h		6 Other (Specification occurred	y)	
o	th: :: Aft	딅	1 X Natural 2 Accident	5 Pending investigation		Jay Year)	Injury	Work	k? Yes 2.⊑				,		
Division		Certification;	3 🗌 Suicide	6 Could not determine	d 28e. Place of	njury - At hor	ne, farm, stre	et, factory, office		28	If. Location (5	Street a	and Number or Rura	I Route Number	
ā	5 # 5 E	ert	4 Homicide		building,	etc. (Specify))				City or Tov	City or Town, State)			
	Hospital		29a. Certifier	1 Certifying	hysicien: To the be	st of my know	rledge, death	occurred at the tim	ne date a	and place, an	id due to the	cause/	s) and manner as e	tated	
	o the nospitation of within 24 hours after To the Funeral Direction of the funeral Direction of the Direction of the fune	edical	(Check only one)	2 Medical Ex	miner: On the basis and manner	or examinate	on and/or inv	estigation, in my or	pinion, de	ath occurred	at the time,	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)			
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and	title of certifier				29c. License	number			29d. Da	ate signed (Month,	Day, Year)	
)	4							(61	4	7		(-196	111	
	2		30. Name and addr	ess of person wh	o completed cause of	death (Item	23a) (Tune F	Print)	0/	-/-/			3/X	101	
			DR. NA	1SRFE.	N/ KAN	CO			0111	AVE	. TA	- K1	MA PA	Rt Md	
	Sta	te	31. Date filed (Mon	ith, Day, Year)	P. Regis	trar's Signatu	761	an 3	2011	IIVC	. (17	10	17/7 //	CN / 10.	
	Registr	-1	JU	N 03 20	105 General	ノゲ	Ire Coss								

			1 - For State Registrar		ryland / Depa <i>Ce</i>	artment rtificate			nd Me		giene	2005	20213	
	Physic /Medi		1. Decedent's Name (First, Middle, La Aurora Avella	net					J	Date of Dea Month	Day	Year 2005	3. Time of Death	
	Exami	ner	4a. Facility Name (If not institution, given Frostburg Vill S. Social Security Number 6. S.	lage Nursi		Fro	stb	ocation of D urg If Under 24			A	County of Dea	ny	
	Funeral Director			1 M 2 🗗 F	(In yrs. last birthday) 96 Yrs.		Days		Min.	Date of Birth (Month, Day Oct 6	, Year) , 190	8 Pu	rthplace (State or Foreign ountry) erto Rico	
	ne Marylan 8a-f show zillied st	Director		egany	10c. City, Town or Lo								10d. Inside City Limits 1X Yes 2 □ No	
,	ath with the 23a or 2 ust be m	rai Dire	10e. Street and Number 56 Green Stree	et.		10f. Zip C	532				10g. Citize	en of What C A	ountry?	
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mucical Examinat must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:	,	Was Decede If Yes, specif 1X Yes 2		Specify:		fy Yes or No- can, etc.)	9	Black, Whi	erican Indian, te, etc. .spanic	
S	ed within 72 t /giene. er than "nati	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) Unknown						16b. Kind	6b. Kind of Business/Industry Own Home				
Maryland	2 should be filed within and Mental Hygiene. Is marked other than "raumatic event, the Market	To Be (17. Father's Name (First, Middle, Last, Juan Bautista 19a. Informant's Name/Relationship (Alicea	105 14:37			Ro	send	First, Middle,	sare	0		
6	s 1 and 2 si f Health an item 27 Is r other traur		Anna Turbin-Gr 20a. Method of Disposition	anddaught	er 56 G	reen	Str	eet,		Route Number Ostbu	rg,	Town, State, . MD 21 ation - City or	532	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.	(1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer	y)	Silbaug	h Cre	emat	ory '	15,2	2005 t	Unio	ntown	, PA	
	99 1 2 9		Hafer Funeral Service, PA 1302 National Hwy, LaVale, MD 21 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a RESP	Consequence of):	Ry ?	PNI	CheTi	U/V	PNI	Zum	NON) A	Interval Between Onset and Death	
. Box 68760,	rate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, recurry to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
	death certific e attending p od for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	Ectopic pregnancy Other (specify)					23	23d. Date of delivery Month Day Year				
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions o	ontributing to death but r	not resulting in the un	nderlying cau	se given	in Part I.				contribute to	the cause of death?	
al Reco	The taw ate has b page 2 s	e Completed	25. Was case referred to medical						-		ned? 2 X No	24b. Were au prior to death? 1 \square Yes	atopsy findings available completion of cause of 2 No	
	S in	Certification; To Bo	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	2 ER/Outpatient 28b. Time of Injury					ence 6[
DIVI	Or a		3 Suicide 4 Homicide 6 Could not be determined		t, factory, office 28f. Location (S City or Town courred at the time, date and place, and due to the c					,				
	within 24 hours a To the Funeral I completely filled	Medical	one)	niner: On the basis of ex and manner stated	camination and/or inv	estigation, in	my opini	on, death or	ace, and ccurred a	at the time, da	ate and pl	ace, and due	to the cause(s)	
) _ '	To To con		29b. Signature and title of certifier HLUW				29c. License number 1 26907				JUNE 14, 2005			
	1		30. Name and address of person who or Dr. Harjit S.			²rint)							~	
	Sta Registr	te ar	31. Date filed (Month Pay Year) 200	5 2. Registrar's	Signature					r-cuill)	-⊥⊥d	HU, M	D 21502	

DHMH 17 Rev 1/2001

Registrar

MAY 2 6 2005

ANDERSON, BARBAR

ORIGINAL

				1 - For State Registrar	State of Ma		partment of F ertificate of	Health and M <i>Death</i>		iene _{og. No.}	05	20215		
		Physici	an	1. Decedent's Name (First, Middle, Last)	ologowth				2. Date of Death Month	Day	Year	3. Time of Death		
/Medical Examiner				Lena Mae Ap	plegarth		4b. City, Town, o	or Location of Death	MAY	<i>3</i> /	y of Death	0853 1		
				Peninsula Regional Medical Central Salisburg						1	Rd			
		be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene.		5. Social Security Number 6. Sex 1 1	7. Age	(In yrs. last birthda 88 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		ace (State or Foreign		
				Usual Residence of Decedent		00			May 30,	1917	Mar	<u>yland</u>		
			ū	10a. State 10b. County MD Wicomico		10c. City, Town or		14 -1			10	od. Inside City Limits 1 Yes 2 No		
9	D		Director	10e. Street and Number	,		10f. Zip Code	lisbury	10	og. Citizen of	What Count			
0	B		al Di	1402 Emerson Ave				21801			SA	.,.		
Ż	B	er dea Items	Funeral		2. Was Decedent E Armed Forces?	ver in U.S. 13	3. Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - America			
	036	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Speci	_{fy:} whi	te		
	21215-0036	filed within 72 hours after death w Hygiene. uther then "neturel", or Items 23a ent, I'ce Madical Examiner must t	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. De	cedent's Usual Occup ve kind of work done	pation during most of working	10	16b. Kind of E	Business/Ind	ustry		
	121	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	.}	. DO NOT use retire cafeteria	during most of working d) worker	.9	publi	c scho	~]		
	ld 2	illed I Hygid Other	Be Co	17. Father's Name (First, Middle, Last)			<u> </u>	18. Mother's Name	(First, Middle, M			<u> </u>		
	ylar	should nd Mer marke umaric	To B	Howard Thomas Le	eCompte			Eva Bur	ton					
	Maryland			19a. Informant's Name/Relationship (Typ Sharon Dean				and Number or Rura				Code)		
		f Health tem 27 other tr		20a. Method of Disposition	niece	20b. Place of Dis	position (Name of	Ave., Sal		MD 2	1801 - City or Tov	vn, State		
	e E	Permit. Page Mary Medical Important: If any injury or any injury or		1 🔀 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	moval from State		er Memoria		/3/05	Cambr	idas	MD		
	Baltimore,			^ 4 □ Donation 5 □ Other (Specify) Dorchester Memorial Park 6/3/05 Cambridge, MD 21. Signature of Funeral Service Scensee 22. Name and Address of Facility Thomas Funeral Home P.A.										
				700 Locust St., Cambridge, MD 21613 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										
_				23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. ASCVD Due to (or as a consequence of):										
0			Ļ	Sequentially list conditions, b.										
			Examiner	if any, leading to immediate cause. Enter Underlying Cause Cheese or mour y that initiated events c.										
28-646	o,	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					-			
20	8760,	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d.		-								
3	9		ician/Me	IF FEMALE: 23	c. If yes, outcome of			234 De	ato of dolling					
33	. Box	death e atter	iciar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal death 3	B□Ectopic pregnancy i□ Other (specify) _	/			ate of deliver onth	y Day Year		
9)	P.0	that the de ed by the detached	Physi	9 Unknown	9□ Unknown				F					
73	ds,	ires tha signed d be de	by	Part II. Other significant conditions conti	ibuting to death but	not resulting in the	underlying cause giv	en in Part I.				cause of death?		
8	Record	aw requires s been si	lete						24a. Was an					
Applegast		The larate has	Completed						autopsy	ed?	prior to com death? 1 Yes 2	sy findings available pletion of cause of		
4	Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	a-ital		To:	26. Place of Death						
4	of	ing Phys	.: To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)										
7	Division		Certification:	27. Manner of Death 28a. Date of Injury 1 Autural 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Accident investigation 28d. Describe how injury occurre										
	ivis		rtific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	street, factory, office	2	8f. Location (Stre City or Town,	et and Numb State)	oer or Aural	Route Number,		
		To the Hospital or A within 24 hours after of the formula process of the formula process of the formula filled in by		29a. Certifier 1 Certifying Physi	rian: To the hest of	my knowledge, de	ath accurred at the tir	no, data and place a	ad due to the sec					
		To the Hos within 24 ho To the Fun completely f	edical	(Check only one)	r: On the basis of e and manner state	xamination and/or	investigation, in my o	pinion, death occurre	d at the time, dat	se(s) and ma e and place,	anner as sta and due to t	he cause(s)		
		To the To the Comp	X	29b. Signature and title of certifier	λ		29c. Licens			d. Date signe				
		9		> VZXa 19	· D ,		1 25	7952		May	3/ 0	2005		
				30. Name and address of person who com Babula Das,		ath (Item 23a) (Type 100 E 0)	1/0// 3	7952 1. 30	Isbun	mo				
	Så.	Sta	5.0		05 32. Peristrar	s Signatural	down							
	100	Registr	ar		De la constitución de la constit									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registra Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 8:52 а м June 1, Granville Leonard Berry 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 3 M 2 □ F 577-18-9207 89 Director Dec. 18, 1915 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 2901 Kensington Boulevard 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No 1944-1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 1946 3 ☐ Widowed 4 ☐ Divorced *natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than *r Elementary/Secondary (0-12) College (1-4or 5+) Railroad Clerk Railroad 10 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Granville L. Berry Blanche Dove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an Ada Marie Berry/ Wife 2901 Kensington Boulevard, Kensington, MD 20895 Health itam 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State injury or 3, June 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francing Address Cornins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COROMARY ARTERY DISEASE Pnysician /Medical GASTROINTESTINAL HEMMORHAGE **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 Wo 1 ☐ Yes 2 ☑ No Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗘 🗞 No 1 Mpatient 2 2 ER/Outpatient 3 DOA of 27. Manner of Death 1 Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attanding 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Momicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trupng Bao MD
31. Date filed (Month, Day, Year) Executive PARK Terri Germantown 13219 State

Registrar

JUN 03

2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 1:30 AM 1160 111 0005 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number #. Age (In yrs. last birthday) **Funeral** Days 1 M 2 1 ONC Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ? is marked other than "natural", or items 23s or 28s-f sho traumetic event, the Medical Examiner must be motified at 1 PYes 2 □ No Director MARYIAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4371 MAXWELL Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after de Hygiena. other than "natural", or item 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20 No IACK Ŕ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONL VINE Work permit. Pages 1 and 2 should be filed Depertment of Health and Mantel Hygis Important: If Item 27 la marked other 17. Fether's Neme (First, Middle, Last) 18. Mether's Name (First, Middle Maiden Sumame) Be CA MENS WINIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2074 6 20b. Place of Disposition (Name of cemajen), crematory or when PRIN9 20a. Method of Disposition Sity or Town, State 1 ☐ Burial 2 ☐ Cremation 3. Removal from State 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Juneral and Address of Facility Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearl failure. List only one cause on each line. Approximate Interval Between **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Examiner or Attending Physician: The lew requiras that the death certificate ba axecuted ng physician and es the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 Diffipationt 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending investigation 1 TYes 2 TNo deeth. Director: A 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C complataly filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred at the cause(s) and manner as stated. Medical 29a. Certifier ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

				partment of Health and N ertificate of Death	Mental Hygier	4000	20218
	Physici		1. Decedent's Name (First, Middle, Last) Berthalene Bro	own	2. Date of Death	Day Year	3. Time of Death $10:25 \text{A}^{\text{M}}$
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapoli		4c. County of Death	h
	Funeral Director		5. Social Security Number 214-48-2174 6. Sex 1 M 2 TF 7. Age (In yrs. last birthda 7.5 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yei May 3, 1	9. Birth 930 Mar	nplace (State or Foreign untry) y Land
	f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel				10d. Inside City Limits 1 ☐ Yes 2√☐ No
	with the N Se or 28a-	Direc	10e. Street and Number 204 Croll Drive	Annapolis 10f. Zip Code 21401	10g.	Citizen of What Co	71
36	s after death	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ ☑ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	e, etc.
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "naturel", or items 23e or 28e-f show event, I're Medical Examiner must be multiped at	Completed t	15. Decedent's Education (Specify only highest grade completed) [Gillege (1-4or 5+)] [Gillege (1-4or 5+)]	cedent's Usual Occupation we kind of work done during most of work to DO NOT use retired)	S	Kind of Business/I	ndustry
and 21	filed Hygi other	To Be Col	17. Father's Name (First, Middle, Last) Maurice McGruder	Oomestic 18. Mother's Name Gonie	e (First, Middle, Maid Bro		
Mary	nd 2 should tith and Ment 27 is marked r treumatic e	Ě	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rura Quiet Waters P	al Route Number, Cit	y or Town, State, Z	(ip Code) MD 21403
more,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other treumatic es		20a. Method of Disposition 1 TyBuriai 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	position (Name of rematory or other place) est Cemetery 6/2	Date 20c.	Location - City or 1	Fown, State
Balti	permit. Departn Importe any inji		Glady q. Sewell 1	22. Name and Address of Facility Se 451 Dares Beach	Rd. Pri	eral Hon	me d.,MD20678
No.	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode of dying, such as cardiac of the mode of	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, a any reading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
.O. Box 68	ne death certif the attending thed for use as	by Physician/Medl		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
Ω.	quires that the signed by ald be detacted.	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc		the cause of death?
al Records,		Completed			24a. Was an autopsy performed?	24b. Were aut prior to co death?	copsy findings available completion of cause of
n of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this centificate ha completely filled in by the funeral director, page	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Annar of Death 1 Natural 5 Pending (Month, Day Year) 27. Mannar of Death Injury	of 28c. Injury at	th (Check only one) me 5 ☐ Residence 28d. Describe how in		ify)
Division of	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street City or Town, Sta		ral Route Number,
	the Hospite in 24 hours the Funere apletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: 6 the best of my knowledge, deal can be compared to the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date a	nd place, and due	to the cause(s)
1	with To 1	Σ	29b. Signature and title of bedfild?	29c. License number 10 3 8 4 4 5	29d. D	Date signed (Month	Day, Year)
	3 Sta	to	30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registra's Signature	Ridy Ava	*/An	nypolo	mo
	Registr		JUN - 3 2005 > Bloom &	Sparte	, E		

		1 - For State Registrar	State of	f Maryland /	-	artment rtificate			and M	lental H	lygier Reg. 1	2 U	05	20219	}
		1. Decedent's Name (First, Middle	, Last)							2. Date of Month		Day	Year	3. Time of Death	
Physi /Med	ician dical	Carol	Lee	Brown						May	30	200		12:23 p	VI .
Exam		4a. Facility Name (If not institution	give street and nur	nber)		4b. City,	Town, or	Location of	of Death			4c. County	of Death		
		Calvert Memoria	al Hospita	al				e Fre				Calve	ert		
Funera	al	5. Social Security Number	6. Sex 1 ☐ M 212 F	7. Age (In yrs. last	• .	If Under Months	1 Year Days	If Under Hours	24 Hrs Min.	8. Date of (Month,	Day Ye	ar)	Cou	place (State or Foreigntry)	gn
Directo	or	579-56-7794	10 W 2K	60	Yrs.					Jan.	9, 1	945	Wash	., D.C.	
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation								Od. Inside City Limit	ts
Manyl f sho	5	MD Calrea	<u>.</u>			~	i.ma							1 ☐ Yes 2 ☑ N	ю
the t	le ct	MD Calve	. L			10f. Zip	wing Code	5			10g.	Citizen of	What Cou	ntry?	
with 3a or	Ö	1012 Wooded The					0736						SA	•	
death with the Maryland ms 23a or 28a-1 show	Funeral Director	1913 Wooded Tra	12. Was Dece	edent Ever in U.S.	13.				gin? (Spe	ecify Yes or Rican, etc.)	No-	14. Ra	ce - Ameri	can Indian,	
of the control of the	臣	1 ☐ Never Married 2 ☑ Marri	Armed Fo ed 1 ☐ Yes	2 No					, Puerto	Rican, etc.)			ck, White,	etc.	
ours a	þ	3 Widowed 4 Divorced	If Yes, Giv Year or Da	'e		1 ☐ Yes 2	No No	Specify:				Specif	y: wh	ite	
Z 1 Z 1 S-UUSO d within 72 hours after death with the Marylan jiene. r then "neturel", or items 23a or 28a-1 show the Mudical Exertines (was be inclined at	Completed	15. Decedent (Specify only highes		1	(Give	dent's Usua kind of wor	k done d	turina mos	t of worki	ina	16b	Kind of B	usin ess/l r	dustry	
within ene.	ם	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	e retired))		3					
e filed wall Hygier other the	S	12			home	maker				·		wn h			
be filed that Hyger of other event,	Be	17. Father's Name (First, Middle,		•						(First, Midd			_		
naryian 2 should be 2 and Mental is marked raumatic ev	은	William Ernes						Nar		orena		loward			
IOre, Maryla ges 1 and 2 should tt of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relations								al Route Nur				Code)	
ore, IV as 1 and 2 of Health item 27 i		Roy H. Brown,	spouse		-					ngs,	-	2073		oun State	
Pages 1		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 Removal from	State		sition (Nam matory or ot							-	own, State	- 1
Dairimo permit. Pages Department of Importent: If it		'4 □ Donation 5 □ Other (S	pecify)	Metro	_					01-05	Al	exand	lria,	VA	
Deparement mpor	- Succe	21. Signature of Funeral Service	icensee			2. Name and			entrino-uni			ALUE DE		20726	
	OI .	William	K CYL							e, P.		UWING	s, M		
		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.					cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death	
Physicia		Immediate Cause (Final disease or condition	a	or as a consequen	1/0	Carl	in	/1	farc.	too				24 hours	12
/Medica Examine		resulting in death)	Due to											3	
ZAGIIIII		Sequentially list conditions,	b	or as a consequen										10 years	
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	CO OI).										
6U, be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to	or as a consequen	ce of):							•			
ate be executed by sician and the burial-transit					,										
oo/ ificate g phys	edlcal		d												
-	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnancy	,							23d. Da	ite of deliv	arv	
BOX leath cer attendir for use	Physician/M	in the past 12 months?		irth 2 Tetal de ant at time of death		Ectopic pre Other (spe							onth	Day Year	
	lsk	1 ☐ Yes 2 🖼 No 9 ☐ Unknown	9□ Unkno	own											
Ords, F.O. requires that the een signed by th nould be detache		Part II. Other significant condition	ns contributing to de	eath but not resulting	ng in the u	nderlying ca	ause give	n in Part I.		23e. Di	d tobacc	o use con	tribute to t	ne cause of death?	
quires n sign	d by									11	Yes	2 🗆 No	3 🗆 Proi	oably 4 Unknow	m
> 0 0	ompleted									24a. W	as an	24b.	Were auto	psy findings available	le
ha:	m d									au	topsy normed 2 X	?.	death?	mpletion of cause of	1
VICAL P sician: Th certificate rector, pag	Ö	25. Was case referred to medical						26 Place	of Death	1 Yes		NO	1 🗌 Yes	2 NO	
	0	examiner? 1 ☐ Yes 2 ★No	Hospital:	npatient 2 ER	/Outpatier	nt 3 🗆 DO	A Othe)C		me 5□Re		6 □Oth	er (Speci	·v)	
Phy Prthis eral d	T:	27. Manner of Death	28a. Date		b. Time of		8c. Injury	at		28d. Describ				,,	
nding ath.	atlo	1 Katural 5 Pendin 2 Accident investig		in, Day rear)	Injury	М	Work 1 □ Y	r res 2 🗌	No						
DIVISION of or Attending Faller death. I Director: After d in by the funer.	ertification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 288. Place	of Injury - At home	, farm, str	reet, factory	, office				(Street Town, St		ber or Rur	Al Route Number,	
To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the	Cert	4 Homelde	Buildi	ng, etc. (Specify)						City of	rown, or	atoj			
ospit hour unere		29a. Certifier Cartifyin	g Physician: To the	best of my knowle	dge, deat	h occurred a	at the tim	e, date an	d place,	and due to the	ne cause	(s) and m	anner as s	tated.	
n 24 he Fu he Fu	edical	(Check only 2 Madical one)	Examinar: On the band mana	ner stated.	andvorin	vestigation,	in my op	oinion, dea	th occurr	ed at the tim	e, date a	and place,	and due (o the cause(s)	
To t withi To t	Σ	29b. Signature and title of certified	1/ /			29c.	. License	number			29d.	Date signe	d (Month,	Day, Year)	
		1 1 VEN /1/	Kushn	~ MY)		02	346	8			5	1311	05	
		30. Name and address of person	who completed cause to shoe	se of death (Item 23	Ba) (Type,	Print)	, ,	_			•	A.		4	
10		Mark 1	Tus har	110	> /	Hospi	4.1	Clos.	-	Cri	ice	to	leci	c/z Ms	2.
	State	31. Date filed (Month, Day, Year)	32. R	egistra s Signature	u	die	M. D								
Regi	strar	JUN	- T YOUS	Doners	N.	1500	45								

		1	For State	State of Ma	aryland / Depa	artment of H		Mental Hygier Reg. I	m mm	20000
			Registrer 1. Decedent's Name (First, Middle, La	st)		imouto or a		2. Date of Death	Jan V I air	3. Time of Death
	Physicia				D				2005	
	/Medic		Simon Dist1 M 4a. Facility Name (If not institution, give		rnest Bar	thes 4b. City, Town, or	Location of Death	May 26,	4c. County of Death	7:50 p ™
	Examin	er					_			TO K+
			1377 Gregg Dr 5. Social Security Number 6.5		e (In yrs. last birthday)		S b y If Under 24 Hrs.	8. Date of Birth	0 Ridhe	vert
	Funeral		The second second	M 2□F	34 Yrs.	Months Days	Hours Min.	(Month, Day, Yea	ar) Coui	DC
	Director	-	213-92-4858 Usual Residence of Decedent		34			1/3/19/	0	DC
	land	ı	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sh	Ö	MD Calv	ort		T.11	sby			1∭XYes 2□No
	28e	e Se	10e. Street and Number	CIU	1	10f. Zip Code	DDY	10g.	Citizen of What Cou	ntry?
	with	0	1377 Gregg Dr	i 170		200	657		USA	
	leath	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race - Americ	
10	fter o	필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ⊠Yes 2 ☐ If Yes, Give		If Yes, specify Cuba		Rican, etc.)	Black, White,	etc.
93	urs a	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:	1994-5	1 ☐ Yes 2 💢 No	Specify:		Specify: Wh	nite
5-0036	72 hours after death with the Maryland natural: or Items 23a or 28e-f show acal Examit et mast be mailfied al	Completed	15. Decedent's E			dent's Usual Occupa		16b	Kind of Business/In	dustry
75	hin 7	pie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)	, and		
2121	d with	Ю		1		Ironwor	ker		Construc	ction
Þ	othe	BeC	17. Father's Name (First, Middle, Last	')			18. Mother's Nan	ne (First, Middle, Maid	len Sumame)	
<u>a</u>	Ald by Alenta Alenta riked	ToE	Frederick Ba	rnes			Evelyr	Lynch		
Maryland	shound N		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number, Cil	y or Town, State, Zij	Code)
Σ	ages 1 and 2 should be filled within 72 hours after death with the Marylan nt of Health and Menth Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show it it item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, it is Maxical Extendition at		Frederick Barr	es/Fathe	r 26125	E. Bro	adway S	t. Walbr	idge, OF	43465
ē,	s 1 a f He item othe		20a. Method of Disposition		20b. Place of Dispo				Location - City or T	
Ę	Page ent o nt: If ry or		1 Burial 2 XCremation 3 C 4 Donation 5 Other (Speci				·	/2005 A1	exandria	, VA
altimore,	permit. Pages Department of 8 Importent: If ite any injury or or once.	İ	21. Signature of Funeral Service Lice	nsee		2. Name and Addres		aymond-W		
ä	Deparimination Department of the series of t		1. (1/1)	1000	F	O Box 4		kirk, MD		, 1 1111
	_		23a. Part1. Enter the disease, or con	plications that cause	d the death. Do not en					Approximate Interval Between
	Observatation		shock, or heart failure. List only Immediate Cause (Final	one cause on each i		nole	+ 41	01. n.m.	+	Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. I'VETO	static	Maligh	an pl	elanding		6/146
	Examiner			500 10 (61 40	a consequence on,					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
	uted J ansit	m.	cause. Enter Underlying Cause (Disease or injury that initiated events							
~~	cate be executed oblysician and the burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence of):					
8760	e be ex sician s buria	dical		d						
.89		O I							1	
Box	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7 =			23d. Date of deliv	rery
ă	leath atte	cia	in the past 12 months?	4☐Pregnant a		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
P.O.	that the de ed by the a detached f	ıysi	9 Unknown	9□ Unknown						
	The law requires that the death certifi tite has been signed by the attending tage 2 should be detached for use as	by PI	Part II. Other significant conditions	contributing to death I	out not resulting in the t	underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
g	uires sign ild be	D D						1 ☐ Yes	2 No 3 □ Pro	bably 4 □Unknown
Ö	n requir been si should I	lete						24a. Was an	24b. Were aut	opsy findings available
Be	he far has ge 2	Completed						autopsy performed	2 death?	ompletion of cause of
<u>a</u>			OF Man area referred to medical				OC Plans of Par	1 ☐ Yes 2	No 1 ☐ Yes	2□ No
Vital Records,	Phyaician: The faw this certificate has be ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	th (Check only one)	2 000000	
o	phy this al d	- To	1 Yes 2 No 27. Manner of Death	28a. Date of Ini	ent 2 ER/Outpatie			ome 5 Residence		(y)
S	ding I h. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Injury		k? Yes 2 □ No			
Division	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not		ijury - At home, farm, si tc. (Specify)	treet, factory, office			t and Number or Rur	al Route Number,
.≥	or A after Dire	ertii	4 Homicide	building, e	tc. (Specify)	•		City or Town, S	tate)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 12 Certifying F	hysicien: To the bes	of my knowledge, dea	th occurred at the tir	ne, date and place	, and due to the caus	e(s) and manner as	stated.
	24 h 24 h Fur etely	edical	(Check only	miner: On the basis and manner s	of examination and/or in	nvestigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	o the	₹	29b. Signature and fitte of certifier			29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
	⊢ ≯ ⊢ ō		Man (1)	Thomas	(X	12	1259	9 5	127/05	
			30. Name and address of person who	completed cause of	death (Item 23a) (Tune		/ /		1/00	
4	4+1	1	Xlene Larsen,		30 Wiscon		# 930	Chevy C	hase, MI	20815
	1 1 1 × C+	ate	31. Date filed (Month, Day, Year)	32. Regis	r s Signature					
	اد Regist		MAY 3	1 2005	Herens &	Coarte				

SIMON DISTL MATTHEW GRNEST BARNES

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voor **Physician** 9, BOWSER 2005 5:53 A May June /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Cuppett- Weeks Nursing Home 0akland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F Yrs. Director 235-44-4134 98 June 3, 1907 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 195 Trailer Court Road 21550 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, if a Madis 2006. Elementary/Secondary (0-12) College (1-4or 5+) 5th Laundry Worker State Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Franklin Sisler ပ Margaret Smith Lucinda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maxine N. Friend-Whiton/Daughter 20222 Mosher Road, Wellington, Ohio 44090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 6/12/05 Terra Alta Cemetery Terra Alta, WV 21. Signature of Funeral Service Ligersee 22. Name and Address of Facility 32 S. Second St. Open Uakland, Md. 21550 Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Dementia Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certified Sam H26154 6/9/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O. Daniel Miller 69 Wolf Acres Drive, Oakland, Md. 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

			For State Registrar	State of	f Maryland /		artment of Hertificate of E		nd Me		giene Reg. No.	005	20222
			Decedent's Name (First, Middle,	Last)				-		2. Date of De	ath		3. Time of Death
	Physicia /Medic		Kay Linda Gumb	inner Rie						Month May	31	Year 2005	8:30 AM ^M
	Examin		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, Town, or	Location of	Death	, ,	4c. C	County of Death	
			848 Harvest Moor				Odenton					ne Arun	
	Funeral			3. Sex 1 ☐ M 24 7xF	7. Age (In yrs. last b	<i>irthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	y, Year)	Cou	nplace (State or Foreign untry)
ŀ.	Director		056-32-2272 Usual Residence of Decedent		67				J	an. 1,	1938	8 New	York
	yland yland		10a. State 10b. County		10c. City, Tox	wn or Lo	ocation						10d. Inside City Limits
	e-fst	ctor	Maryland Anne	runde1	Odento	on							1 ☐ Yes 2 🛣 No
	or 28	Funerai Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
	ath w	ia	848 Harvest Moon				21113					d Stat	
	ier de Items	inne	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed Fo		13.	Was Decedent of His If Yes, specify Cubar	spanic Orig n, Mexican,	in? (Spec , Puerto R	ify Yes or No lican, etc.)	14	 Race - Amer Black, White 	
36	irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Giv Year or D	/e		1 ☐ Yes 2 No	Specify:			5	Specify: w	hite
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-f show the Medical Examinar must be notified at	ted	15. Decedent's	Education	168	a. Dece	dent's Usual Occupa	ition	of workin	2	16b. Kine	d of Business/I	ndustry
21	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT use retired))	OI WOININ	9			
	e filed with al Hygiene. other than vent, the N	Co	47 Fall of Name (First Middle 1	5+		Lobb	yist	10 Mather	da Nama	(Circh Adiddle		ernmen	t
and	be fil ntal H ed ott	Be	17. Father's Name (First, Middle, L Paul Gumbinner	ast)						(First, Middle,	, маюел S	umame)	
Maryland	should be nd Mental marked maric ev	10	19a. Informant's Name/Relationsh	n (Type Print)	19	b. Maili	ng Address (Street a		Cob		er. City or	Town. State. Z	in Code)
<u>⊠</u>	nd 2 s lith an 27 is												
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.		Laura Bienen/ da 20a. Method of Disposition	•	20b. Place	of Dispo	larvest Mo osition (Name of matory or other place	on Dr	. ed	enton,	20c. Loc	ation - City or	Town, State
E O	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from scify)	State		Cremator	1	-2-2	005	Ralti	more.	MD
Baltimore,	permit. Pages i Department of the Importent: If ite eny injury or ot once.		21. Signature of Funeral Service L	icensee	1:					M. Ta	ylor	Funeral	Home, Inc.
<u>m</u>	8 9 E 8		1 2 Scon 1	onwe	teu	1	47 Duke o	f Glo	uces	ter St	. Ann	apolis	, MD 21401
			23a. Part1. Enter the disease, of a shock, or heart failure. List of Immediate Cause (Final	omplications that only one cause on e	aused the death. Do	ne ton c	ter the mode of dying	g, such as d	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	(or as a consequence	راد ه	0 19	- A					year
	Examiner			Co	namow	- -	teant f	ailu	N				Venno
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequence	e of):	15.79.51						/Cut
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events	c	ty ponte		1891						years
30,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to	(oras alconsequence	e of):							7
68760,	physic	dicai	· ·	d									
9 X	death certifics e attending ph id for use as t	Physician/Med	IF FEMALE:	23c. If yes, out	come of pregnancy						23	3d. Date of deli	verv
Вох	seath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		pirth 2 Fetal deal		□Ectopic pregnancy □ Other (s <i>pecify)</i>					Month	Day Year
0	t the by th ache	hys	9 Unknown	9□ Unkn	own								
S,	res tha igned be det	by P	Part II. Other significant condition	s contributing to d	eath but not resulting	in the t	ınderlying cause give	n in Part I.					the cause of death?
ord	law requires as been sign 2 should be		NOU	<u>M</u>						1	Yes 2□	No 3□Pro	bbably 4 Unknown
Records,	e taw r has be je 2 sh	Completed								24a. Was	psy	prior to c	topsy findings available ompletion of cause of
	Th ate pag	Con								1 Yes	rmed? 2 No	death?	2 No
Vita	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only o			
of Vital	Phys this ral di	To	1 Yes 2 No 27. Manne of Death	10	Inpatient 2 ER/C	Outpatie . Time c	nt 3 DOA	at Nur		e 5 Mesi 8d. Describe		Other (Spec	ufy)
O	Attending Property. Attack A	atlon:	1 Natural 5 Pending 2 Accident investig		of Injury th, Day Year) 28b.	Injury	of 28c. Injury Work M 1 🗀 Y	(? Yes 2 □ N	No				
Division	l or Attendi after death. Director: A I in by the to	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	200, Flace	of Injury - At home, ing, etc. (Specify)	farm, st	reet, factory, office		2	8f. Location (Number or Ru	ral Route Number,
Ö	tel or s afte al Dir ed in	Certific	4 LITOMICIO	Dullo							www.ciato)		
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	ledical		xaminer: On the b	best of my knowled asis of examination a ner stated.								
)	To the within To the comp	Ň	29b. Signature and title of certifier	· M :	\mathcal{D}		29c. License	number 5 4 2	99)	29d. Date	signed (Month	
1	5)		30. Name and address of person v	1 /	/1) (Type	D-1-1)				0		
0			31. Date filed (Month, Day, Year)	1600 C	RAIN HW	ιY,	Suite 6	10,	4 6	nuun	nie	, M D	
	Sta Regist		JUN 0	2 2005	gioviai s dignature	1	for the same						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ROBERT KENNETH BROWN MAY 30, 2005 9:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES 6912 ROBINIA ROAD CAMP SPRINGS If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours XXM 2□F 69 Yrs. Director 189 28 6170 19, 1936 PENNSYLVANIA MAR. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 is marked other than "naturel", or Items 23s. or 28e-f sho other treumatic event. It a Madical Executing that be notified at XX Yes 2 No Directo CAMP SPRINGS MARYLAND | PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6912 ROBINIA ROAD 20748 UNITED STATES Funeral death 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "naturel", or Ite 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 Yes XX No Yes, Give Specify: Specify: BLACK à Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH PARKING MANAGER RFK STADIUM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT BROWN CORA LINCOLN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE BROWN / WIFE CAMP SPRINGS, MD 20748 6912_ROBINIA_ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō XX Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL CEM. 6/9/2005 ARLINGTON, VA 21. Signature of Funeral Servi MARSHALL'S FUNERAL HOME OF MARYLAND, INC. lary 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1, there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury as the burial-transit that initiated events resulting in death) Last requires that the death certificate be exec Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Cther (specify) ☐Yes 2☐No the detached 9 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò RENAL FAILURE 1 Yes XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes XX No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) XX Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: XX Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide XX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M23688 03, 2005 JUNE person who completed cause of death (Item 23a) (Type, Print) 10 dress o 30. Name and ØCUIN', JAY/ 106 IRVING ST. NW SUITE 418 WASHINGTON, DC 20010 M.D31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 3 2005 Registrar

			1 - For State Ragistrar	State of	Maryland	-	artment				ental Hy	/giene Reg. No.(2005	20224
	Physicia	an	1. Decedent's Name (First, Middle, Julia A. Burne								2. Date of D Month May	eath 31	2005	3. Time of Death 3:05 a M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numb	ber)		4b. City,	Town, or	Location of	of Death		4c.	County of Deat	h
			8000 Piney Bran						Sprin			Mo	ntgomei	ry
	Funeral Director		5. Social Security Number 227-30-2985 Usual Residence of Decedent	3. Sex 7 1 ☐ M 25 ☐ F	. Age (In yrs. li	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Nov 4,	ay, Year)	9. Birtl Co. Virg	nplace (State or Foreign untry) ginia
	land ow	}	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh	to	MD Montgo	mery	Si1	ver S	pring							X☐Yes 2☐No
	or 28	Olrec	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Co	untry?
	ath wi	ral	8000 Piney Bran					0901				US		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exacilities to confident and once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Divorced	12. Was Deced Armed Force 1 Tyes 2 If Yes, Give Year or Dat	es? 【☐ No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		cify Yes or N Rican, etc.)		I4. Race - Ame Black, White Specify: B1a	
Baltimore, Maryland 21215-0036	thin 72 ho e. an "natur Molical	npleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done a	luring mos	st of workin	g	16b. Kir	nd of Business/l	Industry
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and	ntal H ad oth	Be	17. Father's Name (First, Middle, La								(First, Middle Riddl		Sumame)	
Ž	thould id Me mark matic	2	Thomas Richards 19a. Informant's Name/Relationshi			19b. Mailir	na Address	(Street a					Town, State, Z	in Code)
Ma	nd 2 s lith an 27 is r trau		Brenda Boykin /										ing, MD	
Ē,	of Heal		20a. Method of Disposition		20b. PI	ace of Dispo					ate		cation - City or	
<u>E</u>	Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Doylation 5 ☐ Other (Spe		ale	Calva	arv Ce	emet	erv	June4	,2005	Rich	nmond,	Va.
Balt	permit. Departr Imports any inj		21. Sign Fre of Funeral Service Li	censee FASO	N	22	2. Name and	d Addres	s of Facilit	yJohn:	son an	d Jen	nkins Fu DC 200	ineral Home
	Fnysician	<i>(0)</i>	23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on eac	used the death ch line. Metasta		er the mode	e of dying	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death 6 months
	/Medical Examiner		resulting in death)		r as a consequ									6
	100	-	Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury	b. Pancre	ras a consequ		ma							6 months
8760,	cate be executed chysician and the burial-transit	ilcal Examine	cause. Enter Onderlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ	uence of):								
P.O. Box 6	death certifi e attending i id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		th 2 ☐ Fetal ntattime of de	death 3	Ectopic pre					2	3d. Date of deli	very Day Year
	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant condition Alzheimer's		ith but not resu	ulting in the u	nderlying ca	ause give	en in Part I.	l. 		tobacco us Yes 🕦		the cause of death?
Vital Records,	The lavate has	Completed									24a. Was auto perf 1 \(\text{Yes}		24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only			
of	Phys this ral di	: To	1 Yes 2X No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		8c. Injury Work			le 5 Res 8d Describe		Other (Spec	eify)
lon	Attending ir death. actor: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	, Day Year)	Injury	М		:? Yes 2 □			, ,		
Division	al or Attendes safter death	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Flace 0	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factory	, office		2		(Street and wn, State)		ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	edical	29a. Certifier Check only one) Check only	Physician: To the base xaminer: On the base and manner	is of examinat	wledge, death ion and/or in	h occurred a vestigation,	at the tim in my op	e, date an pinion, dea	nd place, a	nd due to the d at the time	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the To the Comp	N	29b. Signature and title of certifier	. 1	-		29c	. License	number			29d. Date	signed (Month	n, Day, Year)
	Ta		funde 1	1 Sen	rella	10		D35	996			June	1, 200	5
	(8)		30. Name and address of person w	e11, MD 2	2730 Un	iversi	ty B1	.vd.	# 40	0 Whe	aton,	MD 2	0902	
	Sta Registr	_	JUN 0 3 20	05 See	gistrar's Signat	App.	le							

			For State Registrar	State of Mai		d / Depa		lealth and		•	0.5	2000
	Physici /Medic	al	Decedent's Name (First, Middle, Last) MARY JOSEPHINE 4a. Facility Name (If not institution, give s	BEECHE troot and sumber!			Ab City Town	r Location of Deat	2. Date of Death June	Day	Year OOS	3. Time of Death 1:20 AM
	Examin Funeral Director	er	WASHINGTON COUNTY I 5. Social Security Number 6. Sex	OSPITAL	(In yrs. 94	last birthday) Yrs.		AGERSTOWN If Under 24 Hrs Hours Min.	8. Date of Birth	WA	9. Birthp	GTON blace (State or Foreign try) YLAND
	e Maryland te-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND WASHING			y, Town or Lo		ONSBORO				l0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	sath with the	Funeral Director	8507 MAPLEVILLE ROA	AD	er in II	S 12 1	10f. Zip Code	21713			J.S.A	,
900	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23e or 28e-f show ent, the Madical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			1 ☐ Yes 212 No	Specify:	Specify Yes or No- to Rican, etc.)	Specify	k, White, WH	etc. HTE
21215-0036	s within 72 h jiene. r than *natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retired SECRI		rking	6b. Kind of Bu		dustry OFFICE
Maryland 2	ould be filed Mental Hyg karked other latic event,	To Be C	17. Father's Name (First, Middle, Last) CHARLES HENRY HAMI]					LORENE 1	me (First, Middle, M ELLEN TEET	TERS		00001
	t and 2 sh Health and tem 27 is m other traum		PAUL K. RIGGLEMAN/I 20a. Method of Disposition		20b. F	3142		LD RD.,	APT. 209, Date 2		SPR	ING, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. The Madical Examinar must be notified at ODGe.		1 ⊠ Buriet 2 ☐ Cremation 3 ☐ Rivided A ☐ Donation 5 ☐ Other (Specify) 21. Signature of Evident Service Licence		FO:	RT LING	COLN CEME Name and Addre AST FUNER	TERY 6/0	7606 01d Boonsbor	l Natio	nal 1	
	Pnysician /Medical		23a. Part1. Enter the disease of complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line	hi	ratio		ng, such as cardia				Approximate Interval Between Onset and Death
760,	Examiner physician and physician in transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseq	uence of):						
P.O. Box 687	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Feta	Ideath 3	Ectopic pregnancy	1		23d. Dat Mo	e of delive	ery Day Year
	w requires that is been signed by should be detailed	by	Part II. Other significant conditions con	tributing to death but	not res	ulting in the u	nderlying cause giv	en in Part I.				he cause of death?
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Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: T	27. Manner of Death 1 Selatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		28b. Time of Injury	28c. Injur Wor M 1	y at	28d. Describe how	v injury occurr	ed	
Divi	pital or Att urs after d sral Direct		4 Homicide determined	28e. Place of Injur building, etc.	(Specil	5y) 			28f. Location (Stre City or Town,	State)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physical Examir one)	sician: To the best of ter: On the basis of a and manner state	xamina	tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the cau urred at the time, dai	use(s) and ma te and place, :	nner as si and due to	ated. the cause(s)
)	To the To the comp	Z	29b. Signature and title of certifier	2764 8	>	_	29c. Licens	e number	29	d. Date signed	(Month,	Day, Year)
4-1	5		30. Name and address of person who co	mpleted cause of dea	th (Iter	n 23a) (Туре,	Print) OUT+	Hage	curred at the time, dat	n	ary	land
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 6 20	32. Registrar	's Signa	ature D	and the					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 8:34PM 2005 June Ruth Marie Brown 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 💢 F Director 70 June 23,1934 Maryland 216-30-3760 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or items 23a or 28a-f show 1X Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S.A. 21740 12 South Walnut St. Apt 407 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 7 is marked other than "natural", or Items traumatic event, Ite Modical Exertine For Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, Ite Madie one. College (1-4or 5+) Elementary/Secondary (0-12) Nursing Nursing Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sipes 2 Robert Reba (Miller) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tammy Clark / Daughter 13413 Maugansville Rd. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/08/2005 Hagerstown ' 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave Hagerstown MD 21742 23a. Part1. Enter the disease, or compile fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 min Pnysician Infarction Myotordial /Medical Due to (or as a consequence of): Examiner hyperic abstructive

Due to (or as a consequence of) pulmoning Sequentially list conditions Examiner If any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit Du¹ to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical Hyper Lipidemia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Attending (Month, Day Year) 1 Natural 5 Pending investigation after death. 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 10 Hospitai 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/5/2005 mas 00264 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bubura Walnut Street Family Practice 24 N. Walnut St. 32. Registrar's Signature 31. Date filed (Month, State 2005 6 Registrar

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_		Physic		ROBERT ALOIS	S BOINSKI						_Month	Day		I'm U time time !
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3	Ma	d 2 s th an 7 ls i		19a. Informant's Name/Relationship DEBORAH B. CAHALI				Address (Street						p Code)
Esmski	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items any injury or other traumatic event, Ite Model Examiner monne.		20a. Method of Disposition	DAUGITER	20b. P		AVELEY ition (Name of	FARM R	D EAS				
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	ō	g Phy er thi	n: T	27. Manner of Death	28a. Date of Injur	v .	28b. Time of	28c. Injur	4 ∐ Nurs	ing Home	5 Reside	ence 6	Other (Specifi	y)
	ior	Attending death. ctor: After y the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Injury		k? Yes 2⊡No			, and any	00001100	
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		ital o. ral Dii	Certification;		Dullaing, etc	. (Эрөспу)					City or Town	i, State)		
		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Cartifying Pt (Check only 2 Medicel Exar	nysician: To the best on niner: On the basis of and manner state		ledge, death o	ccurred at the tin	ne, date and	place, and	due to the ca	ause(s) a	nd manner as st	ated.
		To the within 2 To the Complet	Med	one) 29b. Signature and title of certifier	/			20a License		Jecumed 8				
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State Registrar 31. Date filed (Month, Day, Year) JUN 0 6 2005



			State of Mar 1 - State Registrar		rtment of Health and N tificate of Death		iene	5 20229
	0		Decedent's Name (First, Middle, Last)			2. Date of Deat Month	th Day Yea	3. Time of Death
	Physicia /Medic	55	Donald T. Chalkley				30 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of D	
			Shady Grove Adventist Hospit		Rockville	100 (0)4	Montgo	
	Funeral		5. Social Security Number 6. Sex 7. Age 577-60-7347	(In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, February	Year)	Birthplace (State or Foreign Country) OUISIANA
	Director		Usual Residence of Decedent	05		realually	O, 1920 L	Juistana
	yland yland		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Man.	ţċ	Maryland Montgomery	Potomac				1 🟋 es 2 🗆 No
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code		0g. Citizen of What	-
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	tams	nue	11. Marital Status 12. Was Decedent Ev Armed Forces?		Vas Decedent of Hispanic Origin? (Sp i Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
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yla	2 should be f and Mental H Is marked o' raumatic ava	701	Harold W. Chalkley	401-14-15				a Tin Code)
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ä	permit. Pages 1 a Department of He Important: If itan any injury pe oth		1 SUNZ Derd	~	P.O. Box	58007 W	Vashingtor	n, D.C. 20037
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		edical	(Check only one) 2 Medical Examiner: On the basis of and manner stat		vestigation, in my opinion, death occur			
	To tha 2 within 2 To tha complet	Σ	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (M	
•	14	/	Biolegia	4	D61681		May 31,	2003
	•	(30. Name and address of person who completed cause of de Robert Kirkcaldy, M.D.	ath (Ithm 23a) (Type, 9901 Medic	eal Center Drive,	Rockvil:	le,MD 20	850
•	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 3 2005 32. Registral	r's Signature	wife			

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ш	Director		207-01-7946	№ M 2□F	87	Yrs.					rch 21,	1918	Penns	yĺvania	a
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	h the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cour	try?	
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Division of \	ng Phys Iter this	ertification; To	3 Suicide 6 Coul	28a. Date (More stigation d not be 28e. Place	of Injury oth, Day Year) e of Injury - At h	28b. Time of Injury	of 2	8c. Injur Wor 1 🗀	y at	280]No	d. Describe h	ow injury or treet and N	Other (Specificcurred	Faci	sted Tity
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	12+1	17.00	30. Name and address of person	on who completed cau	use of death (Ite	m 23a) (Type			11670	577					-/
			Robert Kramen 31. Date filed (Month, Day, Yes	1.5	101 Med: Registrar's Sign	ical Pa	ark Di	rive	, #21	lO, Sil	Lver S	pring	, MD 20	902	
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		-	1 - For State Registrar		State of Ma	•		tment of F <i>ificate of</i>		d Menta	, ,	ne No A	Offi	0000
			Decedent's Name (Fir:	st, Middle, Last)							e of Death	- U U	1,3	3. Time of Death
	Physicia /Medic		Nancy	Ε.		Coury				May		2005	/ear	9:15A M
	Examin		4a. Facility Name (If not i	institution, give st	reet and number)		0	4b. City, Town, o	r Location of De	eath		4c. County o	Death	
			Circle Mano					Kensin				Montgo		
	Funeral		5. Social Security Number	1 1 🗆	7. Age M 2. X F	(In yrs. last birth		If Under 1 Year Months Days		Min. (Mor	e of Birth nth, Day, Ye	ear)	9. Birthp Coun	lace (State or Foreign try)
	Director	}	267-20-2303 Usual Residence of Deci		•	100 Y	13.			Mar	ch 26	,1905	MS_	
	/land			. County		10c. City, Town	or Loca	ation		· · · · · · · · · · · · · · · · · · ·			1	0d. Inside City Limits
	Man a-f sh lijed	to	MD M	lontgomen	y		As	hton						1 ☐ Yes 2 🔀 No
	th the	Director	10e. Street and Number					10f. Zip Code				Citizen of Wh		*
	23a (ai	18600 New H	lampshire	Avenue				20861			nited		
21215-0036	be filed within 72 hours atter death with the Maryland tial Hygiene id other than "natural", or Itams 23a or 28a-f show evant, I're Mudical Exaciline finant be natilised at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐	2 Married	2. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cub ☐ Yes 2X No	lispanic Origin? an, Mexican, Po Specify:	? (Specify Yes	s or No- etc.)		White,	an Indian, etc. ite
5-0	72 h "natu	Completed		Decedent's Educ nly highest grade		(Give ki	int's Usual Occup ind of work done	during most of	working	168	o. Kind of Bus	iness/Ind	dustry
121	within ene.	mpi	Elementary/Secondary	y (0-12)	College (1-4or 5	+)		O <i>NOT u</i> se <i>retire</i> u minu m W				Navy		
d 2	filed withi Hygiene. other than		17. Father's Name (First,	, Middle, Last)			ALU	militam w		Name (First,	Middle, Mai)	
Maryland	2 should be f and Mental b is markad of raumatic eva	To Be	John Coti	Lta					Mary	San An	gelo			
ary	should and Men s marka umatic	-	19a. Informant's Name/F	Relationship (Typ	e, Print)	19b. I	Mailing	Address (Street	and Number or	r Rural Route	Number, C	ity or Town, S	tate, Zip	Code)
	and 2 ealth a n 27 is		Mary L. Pop	pert / I	aughter			New Hap			-			
altimore,	- I a =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre		moval from State	20b. Place of I cemetery	Disposit , <i>crema</i>	tion (Name of atory or other pla	ce) T.,	Date	200	c. Location - C	ity or To	wn, State
Ĕ	Pages Iment of I tant: If it		`4 □ Donation 5 □	Other (Specify)		Gate		Heaven	-	ine 3 2005				in, MD
Ball	permit. Departr Importa any inji		21. Signature of Funeral	I Service Light				Name and Addre						
	00540		23a. Part 1. Enter the of	1 H JU	ations that caused	the death. Do no		er Park					208	/ / Approximate
			shock, or heart fail	lure. List only on	cause on each lin	Pneun			19, 50011 45 541	diag of roopin	atory arrost	•		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.	Duo to /or os	a consequence of		-a 						5 Days
п	Examiner				Due to (or as	a consequence of	1).							
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	iticate be executed g physician and as the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	y c.										
0	e exe		resulting in death) Last		Due to (or as	a consequence of	f):						Щ	
68760,	ate b	edicai		d.										
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 Yes 2 No 9 Unknown	griant iths?	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnanc Other (specify) _	у			23d. Date Mont		ory Day Year
	that ned by deta		Part II. Other significant	t conditions conf	ributing to death b	ut not resulting in	the unc	derlying cause gi	ven in Part I.	236	e. Did tobac	co use contrit	oute to th	ne cause of death?
rds	quires in signi uld be	ed by	Bullous Pe	emphigoi	<u> </u>					_	1 ☐ Yes	2 🗆 No 3	B □ Prob	ably 4 X Unknown
of Vital Records,	aw requin s been si 2 should I	Completed								246	a. Was an autopsy	24b. W	ere auto	psy findings available
R	The lav	mo:									performe Yes 2	d? de	ath?	mpletion of cause of □
ita	ysician: The is certiticate director, pag	Bec	25. Was case referred to examiner?	o medical					The second second	Death (Check	k only one)		_	-
of V	g b	P	1 ☐ Yes 2 📉 No	Ho		ont 2 ER/Out			ner: 4 X Nursin					y)
	ng their	ion:	27. Manner of Death 1 Natural 5	Pending	28a. Date of Inju (Month, Da	ry 28b. Ti y Year) Inj	me of jury	28c. Inju Wo		28d. De	scribe how	injury occurre	ď	
Division	Attending r death. actor: Attention	Certification:	2 Accident 3 Suicide 6	investigation Could not be	28e Place of Ini	ury - At home, farr	m stree		Yes 2 □ No	28f Loc	ation (Stree	at and Number	or Rura	d Route Number,
∑i	after after Dirac	ertif	4 Homicide	determined	building, et	c. (Specify)	iii, stiet	et, ractory, office			y or Town, S		0, 1,0,0	a riodio riambor,
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu				ician: To the best er: On the basis of									
	the H in 24 tha F iplete	Medicai	one)		and manner sta		IIIVC							
	Vitt	2	29b. Signature and title	or certifier		2		29c. Licen				Date signed		
	5					194>			053528		M	ay 31,	200	5
	-		30. Name and address of Daphna Henk						eaton.	MD 208	861			
	Sta	ite -	31. Date filed (Month, D			ar's Signature	-		,					
	Regist		HIM	0.3 200	5 /	K	408	all I						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Tinsley Halter Cunningham June 2005 5:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5215 Norway Drive Chevy Chase Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 82 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 □ F Director 216-14-1643 June 14 1922 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show amounts or other traumatic event, If a Medical Eracia retinast be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Chevy Chase 1 X Yes 2 □ No Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 5215 Norway Drive 20815 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces 1 XYes 2 No If Yes, Give 1941 — Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Chairman Printing Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maxon Cunningham Gwendolyn O'Donahue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Cunningham / Son 6920 Blaisdell Rd. Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 12 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat Cemet Arlington, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 months Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): physician Box 68760. Physician/Medical the as attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by eq XXYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy perform 1 🔲 Yes 20 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 XNatural 1 🗌 Yes death. М 2 No 2 Accident within 24 hours after death 6 Could not be 3 🗍 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and D23556 June 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Robert H. Blee, M.D. 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

			For	Sta	ite of N	/laryland						ental Hy	giene	209.0.6	20222
			1 - State Registrar				Ce	rtificate	e of l	Death			Reg. No	-000	40400
	Physicia	an	1. Decedent's Name (First, Midd									2. Date of De Month	Da		3. Time of Death
	/Medic	_	Evelyn 4a. Facility Name (If not institution	Naomi	and number	Canody	У	4h City	Town or	r Location o	of Death	June	6,	2005 County of Death	7:30 a.n.
	Examin	er						40. Oity,			JI DOGUI		1	St. Mai	
	Funeral		13911 Point 5. Social Security Number	6. Sex	7.	Age (In yrs. la:	st birthday)	If Under Months	1 Year	Ridge If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Vear		place (State or Foreign ntry)
	Director		577-16-5833	1 □ M 2	F	93	Yrs.	Months	Days	nouts		Dec.14	, 19		nington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	,		10c, City,	Town or Le	ocation							10d. Inside City Limits
	Maryl f sho	ţor	Maryland St.	Mary's	ı			Rid	مما						1 ☐ Yes 2 █ No
	r 28a	Funeral Director	10e. Street and Number	11017				10f. Zip					10g. Cit	tizen of What Cou	ntry?
	th wit	al D	13911 Point	Lookou	t Roa	ad			2	20680			Ur	nited Sta	ates
	er dea tems er m	uner	11. Marital Status	An	med Force		. 13.	Was Deced If Yes, spec	dent of H	lispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	D-	14. Race - Ameri Black, White,	
36	rsafte l', or i	by F	1 ☐ Never Married 2 ☐ Mai 3	. If Y]Yes 2∭i Yes, Give ParorDate:			1□Yes	2 2 No	Specify:				Specify: W	nite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Modicel Examiner must be notified at	ted	15. Decede	nt's Education			16a. Dece	dent's Usua	al Occup	ation			16b. K	(ind of Business/Ir	ndustry
215	thin 7 e. an "n	Completed	(Specify only higher Elementary/Secondary (0-12)	- T	ilege (1-40	or 5+)	life.	kind of wo DO NOT us	se retired	during mos d)	t of workir	ng			
	lygien har th		11	141			Sale	es Per	son	10 14-11-	-d- M	(Fine		ail	
and	i be fi ntal H ad ot	Be	17. Father's Name (First, Middle									(First, Middle			
Maryland	should nd Me mark matic	²	Frederick_Ric			·y	19b. Maili	ing Address	(Street			Gertru I Route Numb		or Town, State, Zi	o Code)
	nd 2 saith ar		Louella Canod									lary1an	·		
ore,	ss 1 a of Hea itam otha		20a. Method of Disposition		•	20b. Pla	ce of Disp	osition (Nan	ne of			ate		ocation - City or T	own, State
Ë	Page ment ant: if ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (2		sfiel	d-Ech	ols	Cr.	6-7-2	005	Char	lotte Ha	11. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sinuaturo f Emeral Sance	100	//			2. Name an			DIT			neral Ho	
	0 D ≥ 6 0		Edward N. Bring	sfield,	Jr.									own, MD	20650-0279 Approximate
			shock, or heart failure. Lis				2						irrest,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a	DIMA TO COL	as a conseque		1 0	165	Truc	1700	1			
	Examiner				DGG 10 (01)	us u conseque	1100 01).								
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Ь. —	Due to (or	āš ā Cunseque	ince of).								
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to for	as a conseque	,								
8760,	cate be executed physician and the burial-transit	Ical E	,		00 00	as a conseque	ince on).								
687	ficate p phys			d											
Вох	faw requires that the death certific: as been signed by the attending ph 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant			ne of pregnand		⊒Ectopic pr	onnancy.	,				23d. Date of deliv	•
. B	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No	40		at time of dea		Other (sp						Month	Day Year
P.0.	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant condit				ting in the c	undorh ing o		on in Part I		23a Did	tobacco	usa contributa to t	he cause of death?
ds,	ires tha signed d be del	d by	Dement		ng to death	T Dut Hot 193uii	iiig iii tii o t	maenying c	ause giv	en in raiti			Yes 2	t. 8	bably 4 Unknown
ecords,	v requir been s	Completed										24a. Was	an	24b. Were auto	opsy findings available
Re	9 - o	dmo										auto perfe	psy ormed?	prior to co death?	empletion of cause of
Vital	i cian : Th certificate ector, pag	O	25. Was case referred to medic	aí la						26. Place	of Death	(Check only	2 No	1 Yes	200 110
	8 % =	To B	examiner? 1 □ Yes 2 XNo	Hospita	ıl: 1 □ Inpa	atient 2 🗆 E	R/Outpatie	nt 3 DC	Oth					6 ☐Other (Special	fy)
0 0	fter		27. Manner of Death Natural 5 ☐ Pend.		n. Date of li (Month,	njury Day Year)	28b. Time o Injury		8c. Injun Wor			8d. Describe	how inju	ry occurred	
isio	Attending r death. actor: After	cat	2 Accident invest		. Place of	Injury - At horr	a farm et	M (a closs		Yes 2□		PRf Location /	Street ar	nd Number or Run	al Route Number
Division of	i or A after Dirac i in by	Certification:	4 ☐ Homicide deten	mined 200	building,	etc. (Specify)	10, 101111, 51	reet, lactory	, onice			City or To			ai riodio ramboi,
	To the Hospital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu) and manner as s	
	ha Ho in 24 he Fu pletel	edical	(Check only 2 Medica one)		n the basis		on and/or in	rvestigation	, in my o	pinion, dea	ith occurre	ed at the time,	date and	d place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifi	er .	-	1				e number	- 20	-,		ite signed (Month,	
,			1	20	~				MU	1055	73	,	(017/0:	>
			30. Name and address of person						ah F	2024	Co1:	formi-	M	20610	
	Sta	te	Jennifer Sc 31. Date filed (Month, Day, Yea,	midt,	32. Regi	syll's Signatu	TILE	e Not	CH F	wad,	call	TOLUIA	, PID	20019	
	Registr	ar	JUN	1 0 9 20	על לטו	Colone .	K	And	W.						

Thomas James Craig 05-03927 unpend item/23d,27,26d Type or Print by Plack Indelible Ink. Ensure All Copies Are Legible. d1State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** June 8. THOMAS 2005 :46 A JAMES CRAIG /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Min. Hours 1⊠M 2□F 22 Yrs 3, 1982 Maryland Director Dec. 218.15.6277 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show traumatic evant, the Mudical Examiner must be notified at 1KIYes 2 □ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 20904 U.S.A. Itams 23a 705 Tanley Road death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is markad othar than "natural", or Itar 1 ∐Yes 2⊠No If Yes, Give 157 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Services Restaurant Worker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Lacey Rev. Richard B. Craig 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Indicate the state of the state 705 Tanley Road, Silver Spring, Maryland 20904 of other tr Rev. Richard B. Craig/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/13/2005 Suitland, Maryland Cedar Hill Cemetery ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, Md 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cocaine and Narcotic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Charles (Cause Charles) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month ło Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 XYes 2 □ No P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred The ate of Injury Month, Day Year) Time of Certification: 5 Pending investigation 1 Natural 1 🗌 Yes June 4, 2005 4:30 A unk death 2 Accident after death 6 Could not be 28f. Location (Street and Number of Rural Bouta Number, #303 City or Town, State) 8563 Greenbelt Rd #303 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 🗌 Homicide filled in I Scene Greenbelt Mi within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State Registrar

1 4 2005

29b. Signature and title of certifier

Tanceh

Humeku 31. Date filed (Month, Day, Year)

Southell, MI) Registrar's Signature

nd addres person who completed cause of death (Item 23a) (Type, Print)

29c. License number

OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

June 10, 2005

Baltimore, Maryland 21201

			1 - State of I		artment of Health and rtificate of Death		ene 2005	20236
	Physici	an	1. Decedent's Name (First, Middle, Last)	g		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	TYRONE ALLEN 4a. Facility Name (If not institution, give street and number	CRYMES	4b. City, Town, or Location of De	MAY 29	4c. County of Death	6:23 P M
	Examin	ier	SOUTHERN MARYLAND HOSPI	·	CLINTON	atn	PRINCE GE	
	Funeral Director		577-64-5519 1AM 20F	Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		(ear) 9. Birth	nplece (State or Foreign untry) SH., DC
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	a-fsh	tor	MD PRINCE GEORGE	CAPITOL I	HEIGHTS			1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	untry?
	eath v	Funeral	6968 WALKER MILL ROAD #D		20743	(Specify Ver or No.	U. S. A.	ican Indian
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 271s marked other than "natural", or Items 23a or 28a-1 show or other traumatic avant, Ite Medical Eratrinar must be notified at	by	Amed Force 1 Never Married 2 Married 3 Widowed 4 Divorced Amed Force 1 Mayes 2 If Yes, Give Year or Date	□No	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 🏿 No Specify:	erto Rican, etc.)	Black, White	, etc.
21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of w	rorking 16	6b. Kind of Business/I	ndustry
121	e filed within al Hygiene. I othar than '	ompl	Elementary/Secondary (0-12) College (1-40	or 5+)	DO NOT use retired)		CAMUOTTO O	HADTMITEC
<u>d</u> 2	illed Hygid othar	Be Co	177. Father's Name (First, Middle, Last)			ame (First, Middle, Ma	CATHOLIC C	HARITIES
Vlar	should be nd Mental marked c	To B	VIRGIL CRYMES		BARBA	RA MCPHEAI	RSON	
, Maryland	1 and 2 sho Health and I tam 27 Is me		19a. Informant's Name/Relationship (Type, Print) SHEILA PENN CRYMES-WIFE		WALKER MILL RD.			
altimore,	iges 1 it of H if ital		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from Sta	20b. Place of Dispo cemetery, crer	natory or other place)		c. Location - City or T	own, State
Ħ,	t. Pa rtmer rtant rjury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea	LEE CRI		6-05 CI	INTON, MD	
Ba	Depa Impo any ir	1	Thereton Clinken	er E	Name and Address of Facility P	LNCKNEY-SPA . E. Wash.	ANGLER FUN DC 2000	
	8	v	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1400	oTENSION			Onset and Death
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):	70			
		er	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):	1-arene			(Inknow
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	netastal	to Calon	Carces.	4	Untinous
8760,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or	as a consequence of):				
687	physicate by the control of the cont	dical	d					
Box (eath certific attending p	in/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the program of the pr		Ectopic pregnancy		23d. Date of deliv	rery
O. B	the the	Physician/Me		at time of death 5	Other (specify)		Month	Day Year
, P.O.	that the	V Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	w requires that been signed b should be deta	ed by	Hepatic Enlept	alogoto		1 🗀 Yes	2 □ No 3 □ Pro	bably 4 Upimown
eco	ne faw re has bee ge 2 sho	ompleted	Hyper Enlept	-		24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
œ		Соп				performe 1 ☐ Yes 2 ☐	d? death?	
Zi K	Physician: Th rthis certificate ral director, pag	Be c	25. Was case referred to medical examiner?		Othor	eath (Check only one)		
o o	ding Phys	n; To	1 ☐ Yes 2 ☐ No 1 ☐ Inpa 27. Manner of Death 28a. Date of Ir (Month, I	niury 28b. Time of	28c. Injury at	Home 5 Residence 28d. Describe how		fy)
Sior	Attanding or death. actor: After by the funer	atio	2 Accident investigation	Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of	To tha Hospital or Attanding Physician: within 24 hours after death. to the Funaral Diractor: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of building,	njury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
_	To the Hospital or A within 24 hours after to the Funaral Dira completely filled in by		29a. Certifier 1 ortifying Physicien: To the be	st of my knowledge, death	occurred at the time, date and place	e, and due to the caus	se(s) and manner as s	stated
	To tha Hospita within 24 hours to the Funaral completely filled	Medical	(Check only one) Medical Examiner: On the basis and manner	of examination and/or inv	restigation, in my opinion, death occ	curred at the time, date	and place, and due t	o the cause(s)
	To t for	Σ	29b. Signature and title of certifier		29c. License number		. Date signed (Month,	
14			py pollin	Edeath (Is on)	56454	10	30	101-
U	20		30. Name and address of/perion who completed cause o		I was Sperry	735 Cm	5 Z	
	Sta		31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	5	7 1 347		
	Registr	ar	JUN 0 3 2005 Block	good				

Certificate of Death

20237

Reg. No.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 3 2005

CURTAIN

LIONEL

RICHARD

1 - For State Registrar

2. Registrar's Signature

			1 - For State Registrar		State	of Ma	arylan		artmen rtificate			and M	lental Hy	Reg. No	4000) (202	238
П	Physici	an	Decedent's Name (First, Middle	e, Last)									2. Date of De Month	Da	y Yea	r	3. Time of	
	/Medic	al	Jane	, ,		itt		Car	mpbell	.		15 4	June 2,	2005	0		9:45	A M
	Examin	er	4a. Facility Name (If not institution			итоөг)			Oxon		Location o	or Death			County of De			
	Funeral		6705 Livingsto 5. Social Security Number	6. Sex	au	7. Ag	e (In yrs. I	last birthday)	If Under	1 Year	If Under		8. Date of Bi	th .	ince Ge	irtholac	e (State	or Foreign
Ь	Director		213-38-1774	1 🗆	M XIXIXF	84		Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di August	4^{Year}	920 Nev	Country N Y O	rk	
	pur *		Usual Residence of Decedent 10a, State 10b, County			-	10c. City	, Town or Lo	cation							104	Inside C	ity Limite
	d sho	o	Maryland Princ	e Ce	orgas			n Hill								100.		2 X No
	r 28a	Funeral Director	10e. Street and Number	- 00	01 600		OAOI	1 11111	10f. Zip	Code				10g. Cit	izen of What (Country	?	
	th with	al D	6705 Livingst	on R	oad					2074	5			USA				
	r dea	ner	11. Marital Status		2. Was Dec Armed F	edent orces?	Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spi	ecify Yes or No Rican, etc.))-	14. Race - An Black, Wh			
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes If Yes, G Year or I	ive	No	1	1 □ Yes 2		Specify:		,		SpecifyWh			
9	72 hours after death with the Maryland naturel; or Hems 23a or 28a-1 show Jical E.S.: Jiruff- ust De natified at	ed k	15. Deceder	t's Educa	ation			16a. Dece	dent's Usua	I Occupa	ition			16b. K	ind of Busines	s/Indus	trv	
215	hin 73	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade	Completed College		5+)	(Give life.	kind of wor DO NOT us	k doné d se retired,	luring mosi)	t of work	ng				,	
2	ygiene ygiene ser the	Соп			4			Scho	ol Te	ache					ince Ge	org	es C	ounty
nd	be fill d oth even	Be	17. Father's Name (First, Middle,								_		(First, Middle		Sumame)			
Maryland 21215-0036	hould d Mer marke matic	2	William E. Hew 19a. Informant's Name/Relations		o Print)			10h Mailir	an Addrage	(Street a	Jane		L. Ra	ahn	Tour State	Zin Co	nda!	
Ma	nd 2 s lth an 27 is r		Richard Thompso			w		1					ingfie	-				
ē,	s 1 ar f Hea ltem		20a. Method of Disposition				20b. P	lace of Dispo	sition (Nam	ne of			2005		ocation - City o		-	
Ë	Page nent o int: If iry or		1 ☑ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S		moval from	State		shingt	•					Suit!	land, N	Mary	1and	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, If a M. Alcal Ex., illustrate, and be nutilised at once.		21. Signatur Funeral Service	cense	de			22	2. Name and 6160 Oz	d Addres	s of Facilit	yGeor ad Ox	ge P. Ka on Hill,	las F	uneral H	ome 2074:	2074	
			23a. Parti. Exer the disease, o shock, or heart failure. List	complic	ations that	caused each li	the death									Ap	oproximat terval Bet	ween
A	Pnysician		Immediate Cause (Final disease or condition	a		C	ERE	EBRO	V ASCI	ULA	R	ACO	CIDEN	Ti		Or	nset and i	Death
Ĺ	/Medical Examiner		resulting in death)				a consequ											
	Tata s	-a	if any, leading to immediate cause. Enter Underlying	b.			a consequ	uence of):	LAR		DIS	E 175	.6	-				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ζ.														
o,	an an rial-tr		resulting in death) Last	c.	Due to	(or as	a consequ	uence of):										
8760,	icate be executed physician and s the burial-transit	edlcal		d.		_												
9	death certificate be executed a attending physician and d for use as the burial-transit	/Mec	IF FEMALE:	23	c. If yes, ou	itcome	of preama	nou						- 1				
Вох	atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	20	1 Live	birth	2 Fetal	death 3	Ectopic pre					1	23d. Date of d Month	elivery Da	у ,	Year
P.O.	y the	hysi	1 □ Yes 2 XX No 9 □ Unknown		9□ Unkr				3 0 1.101 (0)01									
	law requires that as been signed b 2 should be deta	by P	Part II. Other significant conditi				ut not resu	ılting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1	obacco u	ise contribute	to the c	ause of d	leath?
ord	v require been sig should b	ted	HABER										1 🗆	Yes 2	□No 3□F	Probably	y 4 □t	Jnknown
of Vital Records,	o = 0	ompleted	PERI PITE	ML	VE	701	us =	ENSU	FFICIE	NC.	1		24a. Was		24b. Were a prior to death?	comple	findings etion of c	available ause of
a		e Co	25. Was case referred to medica									15 1	1 Yes	2 XX No		s 2[] No	
5	Physicien: this certific ral director,	To B	examiner?		spital:	Inpatie	ent 2 🗆 I	ER/Outpatier	nt 3□ DO	A Othe			n <i>(Check only o</i> me 5 ⊊ rResi		6 ∏Other /Sn	acify)		
o	g Phy ter thi neral (27. Manner of Death		28a. Date (Mor	_		28b. Time of		Bc. Injury Work	at		28d. Describe			oury)		
sior	Attending r death. actor: After by the funer	atlo	1 Accident 5 Pendir	gation	(7070)	,	, , , ,	nijary	М		res 2 □ 1	No _						
Division	or Attence after death Diractor: in by the	Certification:	3 Suicide 6 Could 4 Homicide determ		28e. Plac build	e of Inj ding, et	ury - At ho c. (Specify	me, farm, str	eet, factory	office			28f. Location (City or To	Street an wn, State	d Number or F)	Rural Ro	oute Num	ber,
	Hospital		29a, Certifier 1XXCertifyii	n Physi	cian: To th	a bost	of my know	uladae daatl	2 cooured	at the tim	a data an	d place	and due to the		and manner			
	- (V - m	edical		Examine	er: On the land mai	oasis o	f examinat	ion and/or in	vestigation,	in my op	inion, deal	th occurr	ed at the time,	date and	place, and du	ue to the	u. e cause(s	.)
	To the within 2 To the complet	Me	29b. Signature and title of certifie			-			29c	License	number			29d. Dat	e signed (Mor	nth, Oay	, Year)	
			▶ \ \	rl	W					D	130	72	_	Jh.	··· , 6,	200	05	
0	(12)		30. Name and address of person	who com				, , , , ,	,									20
			Gurbux H. Nachnar 31. Date filed (Month, Day, Year,		1D 892	6 Wo	odyaro ar's Signat	d Road	#601	Clint	on, Ma	arylaı	nd 207	735				
	Sta Registr		JUN 0 6 2					dos	B)									
						-		1										

		State of Maryland / Department of Health and Certificate of Death	2000 00000
		Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Deeth 3. Time of Death
	Physician	Iva Elizabeth Curtis	May 28 2005 Year 9:15 pm
	/Medical Examiner		Location of Death 4c. County of Deeth
	Examinet	Calvert Nursing Center Prince	Frederick Calvert
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr. Months Days Hours Min	
	Director	216 44 3203 1 96 Yrs.	March 2,1909 Virgina
	pue ♣	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Vlanyte f sho	Maryland Calvert Prince Frederick	1 X) Yes 2 □ No
	vith the Mar t or 28a-f s be notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	with page 1	85 Hospital Road 20678	U.S.A.
	r items 23s oiner munt Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (
020	n 72 hours efter deeth with the Marylend "natural", or frems 23a or 28a-f show addal Examiner must be notified at leted by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Ves 2 □ No If Yes, Specify Cuban, Mexican, Pue 1 □ Yes 2 □ No If Yes, Give A Year or Dates:	no Rican, etc.) Black, White, etc. Speci White
21215-0020	ed within 72 houygiene. ygiene. ner than "natura rt, the Medical E Completed	15 Decedent's Education 16e Decedent's Usual Occupation	16b. Kind of Business/Industry
3	- 1 2	(Specify only highest grade completed) (Give kind of work done during most of work done during	irking
7	od withing of the Man	10th Grade N/A Supervisor	U.S. Government
p	産工者 9 の		me (First, Middle, Maiden Surname)
Ş			e Comer
Maryland	2 shot end is m	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ural Route Number, City or Town, State, Zip Code)
	ges 1 and 2 should tof Heelth end Mer if item 27 is marks or other traumatic	Donna Drew / Grandaughter 11860 Highview Cip 20a. Method of Disposition (Name of	Date 20c. Location - City or Town, State
Baltimore,	Peges nent of the nent of the nent of the nent of the nent of the nent of or of the nent or or or or or or or or or or or or or	cem etery, crematory or other place)	6/4/05Suitland, Maryland
Balt	permit. Pege Depertment of important: If any injury or pnce.		edar Hill Funeral Home nia Ave. Suitland, Md20746
	EGINES!	23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	c or respiratory arrest, Approximate
	Physician /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Interval Between Onset and Death
	je dinama	- AORTIC STENOSIS	
	cuted nd rensi	0	
Ö,	ficete be executed physician end ss the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1
58760,	hysic the b	that initiated events resulting in death) Last Due to (or as a consequence of):	
_		d.	
Box	es that the deeth certific igned by the ettending p be deteched for use es by Phystcian/Mer		
P.O.	the chad	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco usa contributa to tha cause of death?
	that til ed by detec	ANGMIA, CHRONIC DIARRINGA	1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	The law requires that the deeth certives the hes been signed by the ettending page 2 should be deteched for use e Completed by Physician/M		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
ပ္ပ	w require s been si s should I		completion of cause of death?
æ	The law in ete hes be pege 2 st		1
<u>ta</u>	entifice actor, p	25. Was case referred to medical 26. Place of De	eath (Check only one)
<u></u>	Physician: rthis certific and director.	examiner? 1 Yes 2D No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Inursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
0 0	ng Ph ter th meral	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Sio	Attending or death. Ctor: After by the fune	2 Accident investigation M 1 Yes 2 No	
$\frac{3}{2}$	tal or Attending P rs efter death. al Director: After ti led in by the funers Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The lawithin 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occ	
	within 24 within 24 To the F complete	one) and manner stated.	
	To t com	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Yeer)
	(6)	1 Aligns U 11 COUX USU233	0/2/03
	BU	30. Name end address of person who completed cause of Seath (Item 23e) (Type, Print) (6/2/05- 310 Prince Frederick 20678
		31. Date filed (Month, Day, Year) 32. Registrar's Signaffre	- 3
	State Registrar	31. Date filed (Month, Day, Year) JUN 0 6 2005 32. Registrar's Signa Gre	

DHMH 16 Rev 6/95

		•	State of Maryland / Department of Health and I 1- For State Registrar Certificate of Death		ene g. No.2 0 0 5	20260
	253		1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici		BARBARA LEE SHOCKLEY COWGER	Month 6	Day Year	-10:17AM
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
	_xam.		Atlantic General Hospital Berlin		Worcester	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 12/20/1	Year) 9. Birtl	nplace (State or Foreign untry)
	Director		220–26–1097 1 M 2 🛣 76 Yrs. Months Days Hours Min.	12/20/1	928 Mary	land
	p		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
7	eho	'n				1 ☐ Yes 2X No
6/03/05	ha N	ect	MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
04	with	급			-	unity.
6/01	eath	era		Specify Yes or No-	USA 14. Race - Ame	rican Indian,
20	r Itan	Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	Black, White	e, etc.
777	urs a	þ	3 ★ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ★ No Specify:		Specify: wh	nite
12/20/1928- 215-0036	ba filed within 72 hours after death with tha Maryland ital Hygiene. id other then "natural", or Itams 23a or 28e-f ehow event, I're Medical Extrainer court be neitlied at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	rkina 1	6b. Kind of Business/	Industry
2/2/	ithin 19.	nple	Elementary/Secondary (0-12) College (1-4or 5+)			
N	filed withi Hygiene. other then ent, Ire M		12 Manager		ood Servic	:e
d fu	ba fil Ital H Id oth	Be		me (First, Middle, M Bonnevil		
Barbare-1097 Maryland	should ba filed ind Mental Hygi markad other umatic event, I	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ro			(in Code)
Barban-1097 Maryland	d 2 sl th an 7 le r traur		Paula VanSciver (daughter) 28135 Path Finder Cour			
owyer, 20-26- limore, N	1 and Health tem 27		20a. Michael of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)		20c. Location - City or	
owq.	Pages nent of I int: If its iry or o		1 Landural 2 I Commation 3 Linemoval Port State 1	′2005 I	Pocomoke C	i+v MD
Cowqer 220-26 altimore,		1	21 Signature of Europa al Sorvice Licensee			icy, MD
Ba	permit. Departr Imports any inju		Muchal Dean Holloway Melson Fr 103 Linden Ave.	uneral Ho	me, P.A.	1951
	-		23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a M40C1CList is interested in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in the condition is a m40C1CList in the condition in	`		Onset and Death
	/Medical		disease or condition resulting in death) a. My 0 2 (2) 2 (1) (2) (2) (2) (2) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	<u>. </u>		6 hours
- 28.	Examiner		Sequentially list conditions b.			
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	and and trans	Examiner	Cause (Disease or injury that initiated events c			
760,	ate be executed hysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):			
187	cate t	dical	d .			-
9 ×	leath certifica attending phi d for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	iverv
Bo	atten for u	cian	in the past 12 mopths?		Month	Day Year
P.O. Box 6	the d y the iched	Physician/Med	1 Yes 2 PNo 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown			
<u> </u>	uires that the dei signed by the a Id be detached f	by PI	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	quire in sig uld bu			1 □ Ye	s 2⊡No 3□Pr	obably 4 Unknown
ဝ	aw requir s baen si 2 should	Completed		24a. Was ar		topsy findings available
R	sician : The law certificate has t irector, page 2 s	Ho		perform	ned? death?	2□ No
ita	lan: rtifica stor. p	BeC	25. Was case referred to medical examiner?	ath (Check only one	9)	
<u></u>	Physicia this cert al direct	To		Home 5 Reside	nce 6 Other (Spec	cify)
o u	ding P h. After ti funera	on:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28c. Injury at Work?	28d. Describe ho	w injury occurred	
sio	death.	catl	2 Accident investigation M 1 Yes 2 No	206 Lanation (Car	and and Mumber of Ci	ent Clauta Alumbas
Division of Vital Records,	or At after c Direct in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Ru , State)	rai Houte Number,
	spitel ours cours		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the ca	use(s) and manner as	stated.
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
	To th withir To th comp	Me	29b. Signature and title of certifier 1 physicia 29c. License number	29	d. Date signed (Monti	h, Day, Year)
			1144283		6/3/	05
0.	/>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day Year) 32. Maristrar's Signature		0 0	4.0
C_{\perp}	1, 10		31. Date filed (Month, Day, Year) 32 Societar's Signature	brul	Berken	-, 70
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 6 2005 32. Ingistrar's Signature			

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May **Physician** 28°, 2005 CARTER CORA 9:00Pm ESTHER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital Olney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb 21, 1940 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🕽 F Months Days Hours Maryland 65 Director 219-36-9921 Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturet", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examinet must be notified an any injury on other treumetic event, the Medical Examinet must be notified an once. 1⊠Yes 2□No Director Silver Spring Md Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20906 U.S.A. 14510 Homecrest Rd, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene.

is marked other then "neturet", or Itel 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify ģ Black 3 ☐ Widowed 4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Montg County School Bus Aide 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ellis Jackson Mary Robinson 19a. Informant's Name/Relationship (Type, Print) (Daughte 1) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20906 14801 Rose Trellis Pl, Silver Spring, Md Carole Carter Dorsey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/3/05 Silver Spring, Md Gate Of Heaven * 4 ☐ Done from 5 ☐ Other (Specify) 21. Signature of Funeral Service ^{22. Name and Address of Facility}
Snowden Funeral Home P.A. 20850
246 N. Washington St, Rockville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the burial P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2. ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ANatural 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) Med Der 29c. License number 29b. Signature and title of certifier MIL MGH EI) 0050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MGH MD . Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 02 Registrar

			1 - For MEND#21&22perFHK RegistrapyFND#24a & 26	State of Ma 5/2/05, BMW, Mo per MD 6/2/0	ryland / [Departme <i>Certifica</i>	ent of H	lealth and Death	Mental Hyg	iene2 ()	05	20243
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	Funeral		5. Social Security Number 6. S		(In yrs. last bir	Month	er 1 Year s Days	If Under 24 Hrs Hours Min	(Month, Day	Year)	Count	
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	yland		10a. State 10b. County		10c. City, Tow	n or Location					10	d. Inside City Limits
	B-fst	ctor	MD MONTGO	MERY	TAKON	IA PAR	K					1 Nes 2 No
	or 28	Director	10e. Street and Number	•			Zip Code		1	0g. Citizen of \	What Count	try?
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Ħ	Tant:		'4 □Donation 5 □Other (Specify		CHESA	PEAKE	CREA	AATORY	5/30/2007		SYILI	
Bal	permit. Pages 1 Department of H Important: If itel any injury or ott		21. Signature of Funeral Service Licen Stephen D. Loh	rinann		933, G:	ist A	venue; S	p Funera ilver Spr	ing, M	nation D 20	n Services 910 Wp 250 15
	Physician // Medical Examiner transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	consequence	of):						Interval Between Onset and Death
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<u>α</u>	that the de led by the detached	/ Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the underlying	g cause giv	en in Part I.	23e. Did tol	pacco use cont	ribute to the	e cause of death?
ds	uires n sign	d b							1 □ Ye	es 2□No	3 Proba	ably 4 DUnknown
CO	law requir as been si 2 should l	Completed							24a. Was a	n 24b.	Were autop	sy findings available
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Division of Vital Records,	if or Attend after death Director: / d in by the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, fa . (Specify)			100 20.00	28f. Location (St City or Town		er or Rural	Route Number,
_	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: Atlar this cartificate h completely filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best on the basis of and manner sta	examination an	e, death occurre id/or investigati	ed at the tin	ne, date and plac pinion, death occ	e, and due to the courred at the time, d	ause(s) and ma ate and place,	inner as sta and due to	ited. the cause(s)
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)			1 10/1	5		1.	UN	1717	7	5-2	29-	05
	10		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)	^ ^		/		-	0
				MD6120 W	un ca	ster!	MU	Kol, I	Demodo	s Mi	02	0877
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended 5,6/8/05,LDB,DOR Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** GerAldine 1900 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTI MURE University of MAKY LAND MEDICAL SYSTEM If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 23, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Director 956 Maryland 9- 10-XIDO Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Dorch amb rid 10e. Street and Number 10f. Zip Coo 10g. Citizen of What Country? 5 606-Road 2161 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced Black 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembly-Line Worker Co 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ardenia Gerald Murrell Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cambridge MO. 2161
Date 200 Location - City or Town, State 21613 Frank ark 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6 ambrid 21. Signature of Funeral Service Licensee 22. Name and Addres of Facility
Henry Funeral Home, 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Priysician Ken /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or darking Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. requires that the death certificate be Physician/Medical the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ØYes 2 □ No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: al or Attending P s after death. I Diractor: After t After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

30. Name and address

1 Char

31. Date filed (Month, Day,

of person

Year)

JUN 0 6

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1

29c. License number

South Great Street BALTIMONE

29d. Date signed (Month, Day, Year)

29- 2005

21201

			For State	-	partment of Health and Nertificate of Death		A74	
			Registrar 1. Decedent's Name (First, Middle, Last		orthicate or Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia		Edward Denton D)ize		May 28	, 2005	4:25 A. M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of De	
п			Solomons Nursing (Center	Solomons		Calvert	
	Funeral		5. Social Security Number 6. Se	N 2□F	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	y, Year)	orthplace (State or Foreign Sountry) aryland
	Director		213-40-5260 Usuel Residence of Decedent	62		March 1	3, 1943 Ma	aryranu
	/land		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mar ified	tor	Maryland Calvert	Lusby				1 ☐ Yes ŽÕNo
	or 28	Funeral Director	Maryland Calvert 10e. Street and Number		10f. Zip Code		10g. Citizen of What C	Country?
	23a	ral	12468 Sagebrush Di		20657		United Sta	
	ar dea	nue	11. Marital Status	12. Was Decedent Ever in U.S. Agned Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed	1食Yes 2□No IfYes, Give Year or Dates:Vietnam	1 ☐ Yes 2 🙀 No Specify:		Specify: With	ite
5-0036	be filed within 72 hours after death with the Maryland tal Hygjene. d othar than "natural; or thama 23a or 28a-f show avant, the Medical Exam are must be mutified at		15. Decedent's Ed	ucation 16a Dec	cedent's Usual Occupation		16b. Kind of Busines	
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aryland	2 should be and Mental Is marked o	٩	Gorman Dize	ina Diati	Geneva I			Zin Code)
<u></u>	ages 1 and 2 should b nt of Health and Ment t: If item 27 Is marked r or othar traumatic e		19a. Informant's Name/Relationship (7) Sheryl Griffith —	friend 1246	8 Sagebrush Drive	Lusby M	D 20657	Zip Code)
Baltimore,	f Hea f Hea item		20a. Method of Disposition	nomatan, a	position (Name of rematory or other place)	Date	20c. Location - City of	r Town, State
Ë	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 🔁 Cremation 3 ☐ 1 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	Litan Crematory 6/0	03/05	Alexandria	, Virginia
ati	permit. Page Department Important: If any njury o		21. Signature of Funeral Service Licens	500	22. Name and Address of Facility Rat	ısch Fur	neral Home,	P.A.
<u> </u>	88 5 8		Brown	och 1	1405 Broomes Island	d Rd., I	Port Republ	ic, MD 20676
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not e one cause on each line.	enter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a RESPIRATORY	FAILURE			Lew Weeks
3	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				9
		-	Sequentially list conditions,	b. Due to (or as a consequence of):				Midny years
	nsit	mine	Sequentially list conditions, if any, leading to immediate caus. Exact Disease or injury					
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89	rtifica ng ph	Med	IF FEMALE:					
Вох	leath certific attending pl	an/l	23b. Was decedent pregnant in the past 12 months?		3 ☐ Ectopic pregnancy		23d. Date of d Month	elivery Day Year
P.O.	the all	Physician/Medical	1 Yes 2 No	4□Pregnant at time of death ! 9□ Unknown	5 Other (specify)			
	The law requires that the de tte has been signed by the r bage 2 should be detached t	Ph		ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did 1	obacco use contribute	to the cause of death?
Records,	uires signa Id be	d by	BPH.			1 12	Yes 2□No 3□I	Probably 4 Unknown
CO	w require been signal	lete	GERD			24a. Was	an 24b. Were	autopsy findings available
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ta		0	25. Was case referred to medical		26. Place of Dea			55 Z Bar 110
>	Physici this cer al direc	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Other: 4 Mursing H	ome 5□Resi	dence 6 □Other (Sp	ecify)
0 0	Attanding Physician: r death. sctor: After this certifics by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?		how injury occurred	
Sio	r Attandi er death. ractor: A by the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No	77(1)		
Division of Vital	in Si fie	ertification;	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or To	Street and Number or F wn, State)	Rural Houte Number,
	Hospital 24 hours e Funaral I tely filled	O	29a. Certifier 1 Certifying Phy	ysician: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the	cause(s) and manner	as stated
	To the Hospital or within 24 hours afte To tha Funaral Dircompletely filled in	edical	(Check only 2 Medical Exam	iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	rred at the time,	date and place, and du	ue to the cause(s)
	To the Hospital within 24 hours a To tha Funaral I completely filled	Me	29b. Signature and title of certifier	2 /	29c. License number		29d. Date signed (Mor	nth, Dey, Year)
			1 /5		D36269		5/31/05	
	2		W = 0 0 1 0	completed cause of death (Item 23a) (Typ		.00 = =		
			SCARIA MATHE	-, 1- 8-7-1	789 LUSBY	WD 3	20657	
	Sta Registr		31. Date filed (Month, Day, Year) JUN - 1 2005	32. Registrar's Signature	B			
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irector	Ţ	UNAVAILA Usual Residence of		1 ∆ M 2□F	31	Yrs.		Days	nouis	MIII.	1/1/1		ма1		
show	٦	D.C.	10b. County			ity, Town or L ashin								10d. Inside C	
or 28a-f show e notified at	Funeral Director	10e. Street and Nun	nher				10f. Zip	Codo				10a Cit	izen of What C	1 XYes	
3a or		1800 Sh		st., N	. W .			0011				Ma		Journay ?	
ems 2	ner	11. Marital Status			edent Ever in U	J.S. 13.	Was Deced	lent of Hisp	anic Orig	in? (Spec	ify Yes or Notican, etc.)		14. Race - Am Black, Wh		
or H	by Fu	1 Never Marrie		d 1 ☐ Yes If Yes, Gir Year or D	2.2 X No ve		1 Yes 2		Specify:	Tuono	iouri, oto.)		Specify: B		
atural cal E	ed b		15. Decedent's	Education	ates:	16a, Dece	edent's Usua	I Occupation	on			16b Ki	ind of Busines		
Madi	Be Completed	(Special Elementary/Second	, , ,	College (1-4or 5+)	(Give	DO NOT us	k done dur e retired)	ring most	of workin	g		0. 5.5	amadony	
ygien rt, the	Con			-		uner	mploy					no			
ed off	Be	17. Father's Name (First, Middle, La Douco						8. Mother Fant		First, Middle) T	, Maiden Dian	,		
mark	2	19a. Informant's Na				19b. Maili	ina Address						r Town, State,	Zin Code)	
27 is r trau		Mamadi												n, D.C.	20
ite a		20a. Method of Disp			20b.	Place of Dispo cemetery, cre-				Da	te	20c. Lo	cation - City o	r Town, State	
T of		'4 □ Donation		B □Removal from acity)	State fa	amily	ceme	tery	6	-19	-c5	Bama	akokro	oi, Mal	i
Department or results and water hygiens a returned; or frems 23e or 28e-f show any injury or other traumatic svent, the Medical Examiner must be notified at once.		21. Signal rectiful	neral Service Li	ensee M	aten	2	2. Name and 111 K	d Address d enne	of Facility	Uni	versa N.W.	l Ma	ortua: shingt	cy con,DC	20
ysician ledical		shock, or hear Immediate Cause (I disease or condition resulting in death)	Final	-	ac Arrh	nythmia		e of dying,	such as c	ardiac or	respiratory a	rrest,		Approximate Interval Bette Onset and I	ween
ledical aminer cien and parial-transit	ical Examiner	Immediate Cause (I	Final nditions, mediate rhying injury	a. Cardi. Due to b Due to		nythmia quence of): quence of):		e of dying, s	such as c	ardiac or	respiratory a	rrest,		Interval Bet	ween
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beautive this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	edical Certification: To Be Completed by Physician/Medical	Immediate Cause (I disease or condition resulting in death) Sequentially list confliction of the cause. Enter Under Cause (Disease or in that initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 in the past 12 in the cause (Disease or in the past 12 in the cause (Disease or in the past 12	pregnant months? No cant condition cant condition cant condition cant condition Cant condition Cant condition Cant condition Cant condition Cant condition Cant condition Cant condition Cant condition Cant condition Cant condition Cant condition	a. Cardi Due to Due to b. Due to c. Due to d. 23c. If yes, out 1 \(\text{Live} \) yes 4 \(\text{Pregn} \) yes Unknown s contributing to do Hospital: 1 \(\text{Live} \) 1 28a. Date (Moni t be ed 28e. Place buildi Physician: To the caminer: On the band mani	or as a consection as a consection of as a consection of pregnant at time of cown as a consection of Injury th, Day Year) of Injury - At high, etc. (Special of examination of examinatio	quence of): quenc	DO/ of 28 M reet, factory, h occurred a rivestigation, i	agnancy socify) A Other: Continuous at Work? 1 Yes office at the time, in my opini	in Part I. 6. Place 6 4 Nurs s 2 N date and on, death	of Death sing Home	23e. Did to the at the time,	obacco u Yes 2 an psy ormed? 2 \sum No one dence 6 how injury cause(s) date and 29d. Date	Month se contribute t No 3 P 24b. Were a prior to death? 12 Yes 6 Other (Spe y occurred	Initerval Bet Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset and I Onset I Onse	ween Death 'ear eath?' Inknov availat use o

		4	For State Registrar	State of Maryland	-	artment of F		d Mental Hy	giene Reg. No.	2005	20247
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic	al -	John Roland	Dashiell J	r.				1 200		10:23 PM M
j	Examin	er	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o		eath		County of Death	1
	and the same of th		Wicomico Nursing Home	7 Ago (In use Is	et hirthdayl	Salisbu If Under 1 Year		Hrs. 8. Date of Bi		comico	Opingo (State or Corning
ς	Funeral Director		214-10-7469	7. Age (<i>In yrs. la</i> M 2□ F 88	Yrs.	Months Days		Min. (Month, Di 3/19/	av. Year)	Col	nplace (State or Foreign untry) ryland
	and w	}	Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	f eho	0	Maryland Wicomico	o Sa	alisbu	ry					1X Yes 2 □ No
	28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	untry?
	with 3a or	0	900 Booth St.			2180	1			USA	•
	ns 2:	era		2. Was Decedent Ever in U.S	S. 13. V			? (Specify Yes or No uerto Rican, etc.)	o- 1	4. Race - Amer	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appringut or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		f Yes, specify Cub 1 ☐ Yes 2🌠 No		uerto Rican, etc.)	1	Bfack, White Specify: \f	white
Ö	hour tural	d b	3 Widowed 4 Divorced 15. Decedent's Education	Year or Dates:	16a Deced	dent's Usual Occur	nation		16h Kin	d of Business/li	nduetar
5	n 72 nat	lete	(Specify only highest grade		(Give	kind of work done DO NOT use retire	during most of	working	IOU. KIN	d of business/i	ndustry
7	withii ene. than	Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	Owne		_,		Cor	nstruct:	ion Company
0 0	filed Hygi other	Ö	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden S	Sumame)	
Maryland 21215-0036	ould be Mental arked o	To Be	John Roland Dashie	ell Sr.			Doris	Dishard	on		
lary	2 should and Men le marke aumatic		19a. Informant's Name/Relationship (Type			•		r Rural Route Numb			ip Code)
	1 and 2 Health em 27 othar tr		Ann Taylor/daughter				le Dr.,	Salisbury	-		
ore	of Hor		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	CO	ace of Dispo emetery, cren	sition (Name of natory or other pla		Date		cation - City or 1	
Ĕ	Pages ment of ant; If its lury or o		' 4 □ Donation 5 □ Other (Specify)	Pa		Cemetery		/6/05	Sali	sbury,	MD
Baltimore,	permit. Pag Department Important: I any injury o	ļ	21. September of Formatal Service Literase	'el-	H	Name and Addre	Funeral	Home Pro	fessi	ional As	ssociation
			23a. Payl 1. Enter the disease, or complic shock, or heart failure. List only one	ations that consequences are seen that consequences are each line.	. Do not ent	er the mode of dy	ng, such as car	diac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	FAILURE	A TI	HRIVE					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		TIKE! VC					
	Examiner		Sequentially list conditions b.	CHRONIC	RENI	AL	EALL	WE			
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of Injury	Due to (or as a consequ	ience of):						
	ecute and trans	Examiner	that initiated events c. resulting in death) Last	5							
8760,	ate be executed hysician and the burial-transit		1930king in dodiny cast	Due to (or as a consequ	ience or):						
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical	d.								
9 X	attending for use as	/Me	IF FEMALE: 23	c. If yes, outcome of pregnar	ncy				2	3d. Date of defin	/PD/
Вох	atter I for u	clar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify) _	ey .			Month	Day Year
P.O.	that the death certific ed by the attending p detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	res that signed b	by P	Part II. Other significant conditions cont	inbuting to death but not resu	ılting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
rds	w require been sig should b	pa pa	CUNCIESTIVE HEAD	KT +411	LUPE			1	Yes 2	No 3∏Pro	bably 4 Dunknown
00	aw requ is been 2 shouk	piet	CHRONIC OBCTRUC	TINE PULL	WINH	4 Dis	EASE	24a. Was		24b. Were aut	opsy findings available
Vital Records,	The tte h	Completed	LOUISE EXPENITY	Deep Vena) / (C	THROMB	1.15		ormed?	death?	ompletion of cause of 2⊠ No
ta	ysician: The is certificate his director, page	Be C	25. Was case referred to medical examiner?	700	103	7 (11-27-0(13)		Death (Check only			
	ysic alis ce	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 E	ER/Outpatier	nt 3□ DOA Ot	her: 4 Nursir	ng Home 5 ☐ Res	idence 6	□Other (Spec	ify)
on of	ding Pt. th. After the		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat ork?]Yes 2 ∐No	28d. Describe	how injury	occurred	
Division	r Attenter dealinector	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At hor building, etc. (Specify		eet, factory, office			(Street and wn, State)	Number or Ru	ral Route Number,
Ω	oltal c urs af oral D										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my know er: On the basis of examinat and manner stated.	wiedge, deatl ion and/or in	n occurred at the ti vestigation, in my	me, date and popinion, death of	place, and due to the poccurred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier			29c. Licen			29d. Date	signed (Month	, Day, Year)
	5		Maheren	VI M	D	1-	006051	15	6	12/05	
	E.		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print)			1	1	
	10		Mahesha Thimmarayappa		shore Di	Salisbur	y MD 218	04			
	Sta Registi	_	31. Date filed (Month, Day, Year) , ITIN 0 3 20	32. Restrar's Signat	J. A	parte					

John Dashiell

			State of Maryland / Department of Health and	•	
			1 - Stata Registrar Certificate of Death		2005 20010
			Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	3. Time of Death
1	Physici			Month	Day Year 10:54 PM
	/Medio Examir				4c. County of Death
			Washington Adventist Hospital Tacoma Par	-k	Montgomery Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr		9. Birthplace (State or Foreign Country)
	Director		511-76-1691 13 Yrs. 52 Yrs.	July 30;	1952 Washington DC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary fied	to	DC Washington, D.C.		1 Yes 2 No
	r 28a	rec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	h with	Funeral Director	1315 Maryland Ave., NE 2000Z		USA
	ams er m	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or It	y FL	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:	,	Specify: Rlack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-1 show thir, the Medical Eventrer must be notified at	Completed by	3 Widowed 4 Tovorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	166	. Kind of Business/Industry
15	n "na	plet	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking	. Kind of Business/Industry
212	filed withi Hygiene. Ithar than	mo	Elementary/Secondary (0-12) College (1-4or 5+) Secretary	 	ed. Gov t
	be file ifal Hyg id otha avant,	Be C		ame (First, Middle, Maid	den Sumame)
<u>Vlai</u>	iould b Menía narked natic a	To	Delevan Groomes Alber	ta Hemm	ing
Maryland	2 sho and ls mu		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Facility	Rural Route Number, Ci (1. i Q	ty or Town, State, Zip Code)
	and lealth m 27		Kellya Dabose - Daughter Capital Hats. Macilla	nd 20143)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other than "natural", or Items 23e or 28e-1 show any injury or other treumatic event. Ite Medical Evertimer must be notified at any injury or other treumatic event. Ite Medical Evertimer must be notified at ance.		1 Burial 2 Cremation 3 Removal from State	Date 20c	Location - City or Town, State
Ħ	it. Pa rtmen rtent: njury		'4 □ Donation 5 □ Other (Specify) KeSurretion (em, 16. 21. Signature of Funeral Service Licensee 22. Name and Address, of Facility	-11-03	Clinton, Md,
Ba	permit. Departr Importe any inj		Mach Nieman 767 Kalph Williams	1 4.	Service Service
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.		shington, DC 70003 Approximate Interval Between
	Physician		Immediate Cause (Final DECDID AMEL EALLIDE	-	Interval Between Onset and Death
7	/Medical		resulting in death)		
	Examiner		POST OBSTRUCTIVE LEFT SIDE	O TNEUM	ONTA.
	, p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): BRONCH OF GNIC CALCINDMA		
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. BLONCH OF GWIC CALCINDMA Due to (or as a consequence of):		
760,	te be executed ysician and ie burial-transit	calE	Due to (of as a consequence of).		
687	es that the death certificate be executed igned by the affending physician and be dejached for use as the buriat-transit				
Вох	nding use a	N/M	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
	death e affe	icia	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		Month Day Year
P.0	at the	Physician/Med	9 Unknown		
	The law requires that the death certifica ate has been signed by the affending ph page 2 should be defached for use as if			-	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
Records,	w require been si should I	Completed by	- ACQUILED IMMUMODEFICIENCY SYNDROME		
360	e faw has t	mpl	- 1400 MULTIS INVIVIOUS PICTERS OF SYNDICUTOR	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	n: Th ficate or, pag			1□ Yes 2₽	
of Vital	s certi	To Be	examiner? 1 Yes \2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	eath <i>(Check only one)</i> Home 5 Aesidence	6 Other (Specify)
10	g Phy er fhi			28d. Describe how in	
ior	andin Path. Pat: Aft	atlo	1		
Division	I or Attendi after deafh. Director: A I in by fhe fu	tific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
Q	urs af	Cel			
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Check only one)	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	o the	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	->-0		> K- Luyamtunoan D5336	7 1	VM= 32, 2005
0	(5)		30. Name and address of person who completed cause of death (Item 23a) (TypeyPrint)	MAKMOD	VNG, ND: 20878
<u></u>	0			HIHUILI	VICE, IVID. WESTS.
	Sta		31. Date filod (Month, Day, Year)		
	Registi	ar	JUN 0 6 2005 Klein & Arabe		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 20249 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Year DELAUTER 4, Dona1d Lenwood June 0035 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20014 Sheridan Avenue Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 23, 1924 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 80 Director 219-12-1358 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show The Medical Examiner must be notified at Maryland Washington Hagerstown 1 TYPS 2 NO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20014 Sheridan Avenue 21742 U.S.A. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any injury or other traumatic event, the Medical Eventher 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) pattern maker sand blasting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earl Clayton DeLauter Mary C. Ausherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. DeLauter - wife 20014 Sheridan Avenue, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 7, 2005 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Hagerstown, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Licenses 22 Name and Address of Facility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the distribution and enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proysician disease or condition resulting in death) mon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tho completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Pay) 32. Registrar's Signature State 6 Registrar

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			- State Registrar			Ce	rtificate	e of L	Death		T*	Reg. No.	005	20250	
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	Examin	er	Carroll Hospita			Westminster							arroll		
	Funeral Director		5. Social Security Number 214 62 1214	6. Sex 1 X M 2 ☐ F	7. Age (In yr. 52	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) Dec 4	, Year)	Co	hplace (State or Foreig untry) ryland	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation			-				10d. Inside City Limit	
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	tems her m	ed by Funeral	11. Marital Status	Amed F			Was Deced If Yes, spec	lent of Hi offy Cuba	ispanic Or n, Mexical	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14	 Race - Ame Black, White 		
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	e filed within all Hygiene.	Be Co	17. Father's Name (First, Middle,	Last)		COLL					e (First, Middle,			LOYCU	
an		To B	Robert L. Dodd						Milc	ired	M. Clar	kson-	-Day		
Mar	d 2 sh lith and 27 is m r traum		19a. Informant's Name/Relations Robert Dodd/Son				•	,			ai Route Numbe nertown,			Zip Code)	
ш —			20a. Method of Disposition	0.00		. Place of Dispo	sition (Nar	ne of ther plac	e)		Date	20c. Loca	ation - City or	Town, State	
Ĕ	nit. Pages lartment of h lortant: If Ite injury or or		1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other (S		Me	etro Cr	emato:	ry	į.	6-6-	-2005	Cato	nsville	e, MD	
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. BOX	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Fe nant at time of	etal death 3]Ectopic pr] Other (sp					23	d. Date of del Month	ivery Day Year	
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	The tarate has	Completed									24a. Was autop perfor 1 Yes	an sy med? 2 40	24b. Were au prior to death?	itopsy findings available completion of cause of 2 No	
IIa	Phyeician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?							of Deat	h (Check only o	ne)			
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	Jing L After fune	lon	27. Manner of Death 1 ☐ Natural 5 ☐ Pendir	9	of injury oth, Day Year)	28b. Time o Injury	т 2 М	8c. Injury Work	/at ∢? Yes 2□		28d. Describe h	ow injury	occurred		
DIVISION	r Attention destriction by the	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At ling, etc. (Spe	home, farm, st					28f. Location (S City or Tow		Number or Ru	ıral Route Number,	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical Ce		ng Physician: To th Examiner: On the i											
	within To the compli	Me	29b. Sign ware and title of certil		neu	a M	290	License	nedmun e	54	218		signed (Monti	h, Day, Year)	
رک	12		30. Name and address of person DR. Ramsin	A Kar	eng	349 M		u, c	-lu v	e.		m w	He M	D 21157	
	Sta Registr		31. Date filed (Month, Day, Year,	3 2005	Registrar's Sig	Inature #	banks	j		-					

State of Maryland / Department of Health and Mental Hygiene 2025 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 13:35 June 2005 Jeffrey Everett Martin /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9139 Crystal Falls Road Boonsboro Washington 8. Date of Birth (Month, Day, Year)
Dec. 12, 1956 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**7** M 2□F 48 Yrs. Maryland Director 218-66-4110 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "neturel", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No MD Washington Boonsboro Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code within 72 hours after deeth with 9139 Crystal Falls Road U.S.A. 21713 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpet/Flooring Owner/Operator 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if Item 27 is marked othe eny injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathryn Scott James L. Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Everett/Wife 9139 Crystal Falls Road, Boonsboro, MD 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 6/11/2005 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 5.64m 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Esophageal Adenocarcinoma 18 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): physician a s the burlat-1 Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Cher (specify) 4☐Pregnant at time of death P.0. the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2≦No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Certification: To the Hospitel or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) filled in by 4 Homicide after within 24 hours a To the Funerel [1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 9c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46473 6/6/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind Hamdan, MD; 1130 Opal Court, Hagerstown, MD 31. Date filed (Month, Day, Year) 7 2005 32. Registrar's Signature State Registrar

		•	For State State Registrar	of Maryland		artment of H			giene Reg. No. 2005	20252
			Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physicia		Judith Stacey Morris	Ergott				Month May	Day Year 29 2005	2:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and i			4b. City, Town, or	Location of Death	nay	4c. County of Death	
	LXamiii	C1	116 Alessandra Court				rederick		Freder	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign intry)
	Director		218-78-1095 1□ M 2⊠F	45	Yrs.	Months Days	Hours Min.	(Month, Day Jan, 19	, 1960 Wash	intry)
	ס		Usual Residence of Decedent						,	
	nytan how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f s	ctor	Maryland Frederick		Frede	erick				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?
	th wi	a	116 Alessandra Court			2170	2		United Sta	tes
	ems	iner	11. Marital Status 12. Was Do Armed	ecedent Ever in U.S Forces?	. 13. \	Vas Decedent of Hi	ispanic Origi <i>n</i> ? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
9	or it	by Funeral	1 Never Married 2 Married 1 Yes	s 2 ☑ No		I□Yes 252 No		,	Specify: Wh	
8	72 hours after death with the Maryland 'natural', or Items 23e or 28e-1 show dical Examiner must be notified at		3 ☑ Widowed 4 ☐ Divorced Year or	Dates:					Specify. Wil	
ν.	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade complete	d)	(Give	lent's Usual Occupa kind of work done o	during most of worki	ing	16b. Kind of Business/Ir	ndustry
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ano	be fi	Be	17. Father's Name (First, Middle, Last)					·	Maiden Surname)	
3	i Mer Marke Marke	ဥ	William Wells					Estell		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)						r, City or Town, State, Zi	
ď	l and lealth sm 27		Elizabeth Stup / POA 20a. Method of Disposition	20h Pla		Sition (Name of			aryland 217	
0	f ite		1 ☐ Burial 2 【XCremation 3 ☐ Removal fro	m State cer	metery, cren	natory or other plac	(a)		20c. Location - City or T	own, State
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33	permit Depar Impor Impor Eny in		21. Signature of Associate Licensee			. Name and Addres	טננ		Funeral Home	
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н			23a. Part1. Enter the diselse, or complications that shock, or heart failure. List only one cause of	t caused the death. n each line.	Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arr	rest,	Approximate Interval Between
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Вох	leath certifi attending I for use as	an/l	23b. Was decedent pregnant 23c. If yes, o	outcome of pregnance birth 2 Petal o		Ectopic pregnancy			23d. Date of deliv Month	
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	hour hour ly fill		29a. Certifier Check only 2 Medical Examiner: On the							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	one) and m	anner stated.						
	To T Com	Σ	29b. Signature and title of certifier	> /		29c. License	e number	2	29d. Date signed (Month,	Day, Year)
•				un	5	DI	4625		May 31	2005
	2		30. Name and address of person who completed ca	use of death (Item 2	23а) (Туре,	Print)	7	_	Mny 31	
	2			566 4	501	wno	55	Fred	rocs 4:	0 2170)
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or Ite	Fun	1 Never Married 2 ☐ Married	Armed Forces?				rto Rican, etc.)		Black, White,	
Exe	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Spi	ecify: Whi	te
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han e Me	ig m	Elementary/Secondary (0-12)	College (1-4or 5+)	life	o. DO NOT use retire I / A	d)		N/A		
other t ant, th		17. Father's Name (First, Middle, Las	:t)	N	1/ A	18 Mother's Na	ıme (First, Middle,		mama)	
arked ot atic ever	Be	Robert Ignatius		•			11e Marie	_		
item 27 is marked of other traumatic ev	2	19a. Informant's Name/Relationship			ailing Address (Street	and Number or F	Rural Route Numbe	r, City or To	оwп, State. Zin	Code)
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			1 - For State Registrar	State of Maryla		artment of F		-	giene Reg. No. 0 0	5 2	0254
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La BERNICE B. FINLE Facility Name (If not institution, giv.)	EY		4b. City, Town, o	r Location of Dea	2. Date of De Month MAY	Day	Year 2005	Time of Death 10:50P ^M
	Funeral Director		7508 WALKER MILI 5. Social Security Number 6. S 578 22 1195 Usual Residence of Decedent	ex 7. Age (In yn	s. last birthday) Yrs.	CAPT If Under 1 Year Months Days	TOL HEIO If Under 24 Hrs Hours Min	8. Date of Bir	th ly, Year)	NCE GEO 9. Birthplace Country) WASHIN	(State or Foreign
	ath with the Maryland 23a or 28a-f ehow ust be notified at	ctor	10a. State 10b. County MARYLAND PRINCE		City, Town or Lo					Х	nside City Limits 【ሺYes 2 ☐ No
2	0 2 0	by Funeral Directo	10e. Street and Number 7508 WALKER MILL 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ZZ No If Yes, Give		Under the state of the state o	0743 dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or Norto Rican, etc.)	Black		
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7	at Hygin d other event, t	To Be Con	12TH 17. Father's Name (First, Middle, Last, UNKNOWN)	HO	OMEMAKER	18. Mother's Na		PR , Maiden Sumame	RIVATE	
>	Pages 1 and 2 should to hent of Health and Ment int: If item 27 Is marked int or other treumatic e	-	19a. Informant's Name/Relationship (HARRIET EDWARDS / 20a. Method of Disposition XX Burial 2 Cremation 3	DAUGHTER 20b. Removal from State	7508 Place of Dispo	WALKER M sition (Name of matory or other place	and Number or R	CAPIT	OL HEIGH	ITS, MD City or Town, S	20743 State
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200	The law requires ate has been sign page 2 should be	Completed by P	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	XX 24a. Was autop	an 24b. W	3 Probably	4 Unknown indings available tion of cause of
חומונות אונמו	*Attending Physicien: Ther death. rector: After this certificate by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes XX No 27. Manner of Death XX Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor M 1	en: 4 Nursing I	28d. Describe	dence 6 Other	d	ute Number.
5	e Hospitel or Att 24 hours after de 8 Funerel Direct etely filled in by t	edical Certif	(Check only 2 Medical Exar	building, etc. (Specials) building, etc. (Sp	cify) nowledge, deat	h occurred at the tin	ne, date and plac	City or Ton	wn, State) cause(s) and man	ner as stated.	
^	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.	The state of the s	29c. Licens		3,000 0,000	29d. Date signed JUNE 02	(Month, Day,	Year)
<i>ل</i>	Sta Registi		30. Name a Hamiless of person who CARL JOHNSON, M 31. Date filed (Month, Day, Year)	Registrar's Sig	1 MERCA	NTILE LAN	NE UP	PER MARL	BORO, MD	20774	

			for State RegistrarAVEND#28A-Ft	State of M		_	artment of I			-	giene Reg. No. 2 (20255
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	Funeral Director		5. Social Security Number 579–52–1375 Usual Residence of Decedent		7 5		If Under 1 Year Months Days	If Under Hours	24Hrs. Min.	8. Date of Bir (Month, Da Dec. 18,	th y, Year)	9. Birthp Court Irela	lace (State or Foreign
	or death with the Maryland tems 23a or 28e-1 show at most be multiped at	Director	10a. State 10b. County Maryland Montgo 10e. Street and Number	mery	10c. Cit	y, Town or Lo	Olney 10f. Zip Code				10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2X No
036	or ite	by Funerai	3920 Brooke Meado 11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?			208 Was Decedent of H f Yes, specify Cub			ecify Yes or No Rican, etc.)	14. Ra	USA ace - Americ ack, White, ify: White	etc.
Maryland 21215-0036	d within giene. ir than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	i+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire nemaker	during mos	st of workii	ng	16b. Kind of I	Business/Ind	
aryland	be d o d o	To Be	 17. Father's Name (First, Middle, L. James Dowling 19a. Informant's Name/Relationshi 			19b. Mailie	ig Address (Street	Ma	argare	t Murphy		,	Co <i>d</i> e)
Baltimore, M.	of Health If item 27		Jeremiah F. Fahey/ 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	0	3920 H lace of Dispo	brooke Mead sition (Name of natory or other place aven Cemet	ow Lane		ey, MD 2	0832 20c. Location	- City or To	
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of Vital Records,	The larate has	Be Compi	25. Was case referred to medical					26 Diago	of Dooth	24a. Was: autop perfor 1 Yes	med?	Were autop prior to com death? 1 \(\text{Yes} \) :	sy findings available apletice of cause of
of V	Physicien: r this certific ral director,	၉	examiner? 1 Tes 2	Hospital: 1 Anpatie		ER/Outpatien 28b. Time of		er: 4 ☐ Nu	rsing Hom	ie 5□Resid	ence 6 ⊡Oth ow in f ury occur)
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Ω	To the Hospitel or Attentwithin 24 hours after deall To the Funerel Director: completely filled in by the		29a. Certifier 18 Certifying (Check only 2 Medical Ex	Physician: To the best	of my know	wledge, death	occurred at the tin	ne, date and	d place, a	ad due to the	auso(s) and m	anner as sta	ited.
	To the hwithin 24	Medicai	one) 29b. Signature and titte of certifier	and manner sta	led.		29c. Licenso	e number		2	9d. Date signe	ed (Month, D	Pay, Year)
	12		30. Name and address of person wh	no completed cause of de	eath (Item	23a) (Type, I	Print) Service, M.)(e/	07	3 /	Mag	28,	2005
	Sta	4	Minee O K 31. Date filed (Month, Day, Year)	WLID, MD	20 r's Signat	0500 _	Serece, M.	e active.	STrk	uy, G	ermento	OUN	20816
	Registr	ar	JUN 02	2005 Homene	, ,0	16,000	C. C. C. C. C. C. C. C. C. C. C. C. C. C						

		For State Registrar	Stat	e of Mar		artment of F rtificate of		Mental Hyg	iene og. No. 005	20256
Dhunia		1. Decedent's Name (First, Mic	ddle, Last)					2. Date of Deat Month		3. Time of Death
Physic /Med		Patricia	C	ollins		Foster		May 29		12:30a
Exami	ner	4a. Facility Name (If not institu		d number)		4b. City, Town, o	or Location of Dea	ath	4c. County of Dear	th
		Holy Cross H	ospital 6. Sex	7 Amn /	la un la at historia.	Silver	Spring If Under 24 Hr	e 0 Data (Bist)	Montgome	ry
Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 ☐	}-F	(In yrs. last birthday) Yrs.	Months Days	Hours Mir	1. (Month, Day,	rear) Co	thplace (State or Foreign buntry)
		579 26 9703 Usual Residence of Decedent			82			January	26 1923 Wa	shington DC
ylanc how		10a. State 10b. Cour	nty	1	10c. City, Town or Lo	ocation				10d. Inside City Limits
e Ma	cto	Maryland Mo	ntgomery		Silver Sp	oring				1 ☐ Yes ŽŽNo
ith th	Directo	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What Co	ountry?
ath w	rai	320 Vierling				209			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medicul Event and minist be inclified at any other.	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 □ Widowed 4 ♣ Divorce	Arm larried 1 []	Decedent Eved Forces? Yes 2 Nos. Give		Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit	
vithin 72 ho	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	lent's Education hest grade comple 2) Colle	eted) ege (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo d)	orking	16b. Kind of Business/	Industry
iled v dygie thar t	ပိ	12 17. Father's Name (First, Midd	la / act)		I	lomemaker		ame (First, Middle, N	Own Ho	me
allo dbe file ntal Hy ad oth	Be							•	iaiden Sumame)	
hould d Me mark matic	2	Patrick Colling		·)	10h Maili	na Addrose (Strant		Johnson Number	City or Town, State, 2	Tin Code l
id 2 s ith an ith an 27 ls i		James L. Foste		,						
Chem 3		20a. Method of Disposition	or , bon		20b. Place of Dispo	sition (Name of			ng, Maryla 20c. Location - City or	
Deartification Department of mportant: If it any injury or contract.		Y Gurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other		from State		natory or other pla	, I	10.1000= =		
mit. Frankmartme		21. Signature of Funeral Sprvi			Gare of E	leaven Cer 2. Name and Addre	metery 6	/2/2005 S	ilver Spri di Funeral	ng, Marylan
g Ferring		- Kinon	Ileu	Jon		800 New	nı Hamnehir	nes Kinal	di runeral	ноте • MD 20904
Physician /Medical Examiner bhysician and the burial-transit		2.a. Part1. Enter the disease, shock, or her it failure. Limited the Lause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Ventr e to (or as a c Ather e to (or as a c	icular Ar consequence of): consequence of): consequence of):	rhythemia	a		SI.	Approximate Interval Between Onset and Death
ate be exhibiting the buria	dical		l d							
	ledi								1	
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	101	s, outcome of Live birth 2 (Pregnant at tin Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	y		23d. Date of deli Month	ivery Day Year
quires that n signed k	by	Part II. Other significant cond Hypertension	itions contributing		not resulting in the u		ren in Part I.		acco use contribute to s 2 □ No 3 □ Pro	
ysician: The law requir sis certificate has been si director, page 2 should	Completed							24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
vician: The certificate	Be C	25. Was case referred to medi	cal				26. Place of De	1 ☐ Yes 2		20140
Physician: This certific ral director,	10.	examiner? 1 ☐ Yes 2 X No	Hospital:	1 XInpatient	2 ER/Outpatier	t 3 DOA Oth	er: 4 🗌 Nursing I	Home 5 Resider	nce 6 Other (Spec	eity)
ng ung	ertification;		ding stigation	Date of Injury (Month, Day Y	/ear) 28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	w injury occurred	
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 286.	Place of Injury building, etc. (r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or At within 24 hours after or To the Funaral Direct completely filled in by	edical	29a. Certifier 1 ★ Certification (Check only one)	ai Examiner: On	o the best of r the basis of ex manner stated	xamınation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To With	×	29b. Signature and title of certification	tier a	726	1	D2	e number	ļ	d. Date signed (Month May 31, 20	
~		30. Name and address of person	on who completed							
	010	Marie Dobyns, 31. Date filed (Month, Day, Yea	M.D.	7350 V. Registrar's	an Dusen	Parkway #	320 Lau	rel, Maryl	and	
St Regist	ate trar	JUN 03	2005	Com	B. Age	Les of the second				

			State of Maryland / De	epartment of F			71115	20257
			Registrar 1. Decedent's Name (First, Middle, Last)	Crimoate or		2. Date of Death	No: 9 0 0	3. Time of Death
	Physicia		Mary Frazier			May 27,	Day Year	6:44 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death		4c. County of Dea	
			Holy Cross Hospital	Silver			Montgom	ery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug • 20,	(ea <i>r</i>) 9. Bird Co 1918 Ma	hplace (State or Foreign cuntry) ryland
	pur *	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location				10d. Inside City Limits
	Maryla 1 sho	ō	D.C. N/A Washin					1X Yes 2 □ No
	r 28a-	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	ountry?
	h with	ai Di	757 Quebec Place, N.W.	20010		U	Inited Sta	tes
36	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28a-f show event, I've Medical Exactiver must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of H If Yes, specify Cuba Yes 2X No 	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	city Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
Ö	2 hou atura	ted	15. Decedent's Education 16a. D.	ecedent's Usual Occup	pation	16	6b. Kind of Business	Industry
21215-0036	thin 7 e. en "n Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done fe. DO NOT use retired	d)			
N	ed wi	Con		othes Pres			ry Cleane	rs
and	2 should be filed von and Mental Hygie	Be	17. Father's Name (First, Middle, Last) George McGowans		18. Mother's Name Fannie D		uden Sumame)	
2	d Mel d Mel mark	^L		failing Address (Street			City or Town State.	Zin Code)
<u>≅</u>	nd 2 s lith an 27 la r trau			Peabody St				
re,	t Hea Heam Hem		20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place	Da		c. Location - City or	
Ë	Page Int: F		1 ABurial 2 Cremation 3 Removal from State	y Memorial	6/4/	05 I	andover,	Maryland
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury peother traumatic evones.		21. Signature of Funeral Service Licensee		ess of FacilityMcGu			ce D.C. 20012
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.					Approximate Interval Between
1	Pnysician		Immediate Cause (Final disease or condition a Cardiac Arryth					Onset and Death instant
	/Medical		resulting in death) a Due to (or as a consequence of)					Indunt
	Examiner		Sequentially list conditions, b.					
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Lease or in Jury that initiated events c.	÷				
	xecut and al-trar	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of)	:				
8760,	icate be executed physician and s the burial-transit	dicai E	d					
9	ufficate g phy as the	ledic	<u> </u>					
). Box	ie death certificate be executed the attending physician and hed for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date of de Month	livery Day Year
P.0	that the died by the detached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause oiv	ven in Part I	23e. Did toba	cco use contribute to	the cause of death?
ecords,	w requires t been signe should be	ted by	ASCVD			1 ☐ Yes	2 □ No 3 □ P	obably 4X1Unknown
ecc	aw as b	Completed	Gastrostomy Tube			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E E	: The l cate ha	Con	Dementia			performs 1 ☐ Yes 2X	ed? death? □ No 1 □ Yes	2 X) No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: 15 leasting 2 M SR (Outs.)	ationt 30 DOA Oth	26. Place of Death			
of		T. To	27. Manner of Death 28a, Date of Injury 28b. Tim	atient 3 DOA	4 LI Nursing Hon	ie 5 ∐ Resideni 8d. Describe how	ce 6 □Other (Spe rinjury occurred	cify)
on	Attending F r death. sctor: After by the funer	tion	1 ∑Matural 5 ☐ Pending (Month, Ďaý Year) Inju 2 ☐ Accident investigation		rk? ∣Yes 2 □No			
Division	if or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	ı, street, factory, office	2	8f. Location (Stre City or Town,	et and Number or R	ural Route Number,
	spital or At ours after o veral Direct filled in by	Cert					,	
	Hos Fur ely	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/one) (Check only one)	leath occurred at the til or investigation, in my o	me, date and place, a ppinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within 2 To the Complet	Ň	29b. Signature and title of certifier	29c. Licens	-		d. Date signed (Mont	h, Day, Year)
)	6		Arra	Doc	2865	6	May 31, 2	2005
	V		30. Name and address of person who completed cause of death (Item 23a) (Ty Ravi Passi, M.D. 15225 Shady Gro	ve Road #20	08, Rockvi	11e, MD	20850	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 2005 32. Registrar's Signature	loseli				

			1- State of Maryland / Department State of Maryland / Department State Registrangend item #26 per verb 8844 Gerti			iene, 005	20258
	Physici	an	1. Decedent's Name (First, Middle, Last)	Gault	2. Date of Death Month June 5, 20	Day Year	3. Time of Death 2:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4	4b. City, Town, or Location of Death	oure 3, 20	4c. County of Death	2:W F
	Ŷ		3501 29th Avenue	Temple Hills If Under 1 Year If Under 24 Hrs.	0.00	Prince Geo	
П	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, October	Year) 9. Birthi Cou. 10,1923 Ne	place (State or Foreign ntry) W York
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ition			10d. Inside City Limits
	Marylan a-f ehow	tor					1 ☐ Yes 🛣 No
	vith the	Director	10e. Street and Number 3501 29th Avenue	10f. Zip Code 20748	10	og. Citizen of What Cou	ntry?
	ms 236	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Americ	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23c or 28a-f ehow or other treumetic event, the Modical Exami	by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	es, specify Cuban, Mexican, Puerto Yes 2□xNo Specify:	Rican, etc.)	Black, White,	
15-0	"natu	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kind in the completed)	nt's Usual Occupation nd of work done during most of worki DNOT use retired)	ng	16b. Kind of Business/In	_
212	filed within Hygiene. other then ent, Ire M	dwo	Elementary/Secondary (0-12) College (1-4or 5+) Office	e Manager		Vashington, Public Scho	
	2 should be filed withir and Mental Hygiene. is marked other then eumetic event, Ine M	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N		
Maryland	should be fand Mental is marked o	2		Clara May		City or Town, State, Zig	Code)
	and 2 sealth ar		Paul Gault / Son 3501 29	9th Ave., Tem le	·		
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	! _		20c. Location - City or To	
altin	permit. Pa Departmen Importent: eny injury			Name and Address of Facility		Edgewater, 1	
ä	Depar Impore eny ir			60 Oxon Hill Road Oxo			P.A.
			23a. Partite the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final	he mode of dying, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a consequency of):	- Junium V			
	Examiner	L.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	noun			
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	xir.			
8760,	be executed ician and burial-transit	i Exa	resulting in death) Last Due to (or as a consequence of):				
687	ficate be ex physician ts the buria	edical	d				
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M		ctopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	uires that the d signed by the d be detached	oy Ph	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
Records,	w require been si	Completed	Chamile Walter	Trada com Mari Dist	100		ably 4 Unknown
Rec	he law e has t age 2 s	duuc	O Turmaro	Waniana Disa	24a. Was an autopsy perform	ed? prior to co	psy findings available mpletion of cause of
Vital		Be C	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 🕺		2 No
of V	Physicien: this certific	ြို	1 Yes 25 No Hospital: 1 Inpatient 2 56 Outpatient 28a. Date of Injury 28b. Time of		me XXX Resider 28d. Describe hov	nce 6 Other (Specif	y)
lon	ling After fune	atlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	28c. Injury at Work? M 1 Yes 2 No	LOG. Describe not	willing occurred	
Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
	ospitel hours a unerel f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place,	and due to the car	use(s) and manner as s	tated.
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invessione) and manner stated.	stigation, in my opinion, death occurred			
	To wit		29b. Signature and title of certifier Pull Mark D. Supplyment	D72876	29	d. Date signed (Month,	2005
P	(7)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri			V UVILL O	
		10	Glenn Edgecombe MD 7700 Old Branch Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature		land 2073	35	
	Sta Registr		JUN 0 6 2005	'			

			For State Registrar	State of Maryland		artment rtificate				giene Reg. No. 2 (Market State of State	2026
	Physici		1. Decedent's Name (First, Middle, Last Diane		Hebb				2. Date of De Month May		20Ö5	3. Time of Death 7:20P M
	/Medic Examir		4a. Facility Name (If not institution, give 301 Moonlight	Drive		Pr	ince	ocation of Death Frede	rick	4c. Coun	ty of Death Calv	ert
	Funeral Director		5. Social Security Number 217-72-9547 Usual Residence of Decedent	x 7. Age (In yrs. la ☐ M 2 ☐ X 4.7	Yrs.	If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Nov. 3	, 1957	9. Birthp Coun Mar	lace (State or Foreign try) yland
	ie Maryland Ba-f show	Director	Maryland St.	Mary's	Town or Lo	xing	ton	Park				0d. Inside City Limits 1 ☐ Yes 2 ▼No
	th with the 23a or 24		10e. Street and Number 47420 Sewe11	Road		10f. Zip (653		10g. Citizen o		itry?
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medicel Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decede If Yes, speci 1 Yes 2		panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ace - Americ ack, White, afy: B1 a	etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give life. i	dent's Usual kind of work DO NOT use Homer	done dui retired)	ring most of worki	ng	16b. Kind of	Business/Inc	dustry
rland 2	uld be filed Jental Hygi rked other tilc event, I	To Be C	17. Father's Name (First, Middle, Last) Alonzo	Chew			- 1	8. Mother's Name E11a	(First, Middle,		ame)	
	and 2 sho ealth and A m 27 is ma		19a. Informant's Name/Relationship (T) Vernon R. Hebb/	Husband	P.O.	Вох	833		ngton :	Park,	MD 2	0653
3altimore,	Pages 1 Iment of H tent: If Itel jury or oth		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify,	Removal from State So.	metery, crer Mem		rden	s 5/31/			lrk,	MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licens Slocky G.	Sundj	1		Dare	s Bch.			1 Ho	me .,MD2067
8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Litter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	a. UR E M Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque C. Due to (br as a conseque Due to (br as a conseque	ence of): fail ence of): Sive	ar the mode	or aying,	lasetre	respiratory ar	vro fa	thy	Approximate Interval Between Onset and Death
Box 6	ne death certific the attending p hed for use as	Completed by Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ ¶o 9 □ Unknown	23c. If yes, outcome of pregnan- 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	Ectopic pre					ate of delive	ry Day Year
rds, P	w requires that the second of	d by Pl	Part II. Other significant conditions co	ntributing to death but not result	1 1	nderlying car	Λ	in Part 1. Stroke	23e. Did to		ntribute to th	e cause of death?
Reco	The law rec ate has bee page 2 shou	Complete	Diabetes mell factore to	the spert	ensi ar	v /	An	emfa	24a. Was autop	an 24b sy rmed? 2 No	. Were autor prior to con death?	osy findings available npletion of cause of
of Vita	Physicien: this certificanal director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		R/Outpatien	it 3 DOA	Other:	4 Nuising Hot	(Check only only only only only only only only	lence 6 🗆 O		<i>'</i>)
Division of Vital Records, P.O.	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At hom building, etc. (Specify)	Injury	М		s 2 No		Street and Nurr		Route Number,
	he Hospite n 24 hours he Funerel pletely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinatio and manner stated.	ledge, death on and/or inv	occurred a vestigation, i	t the time, n my opin	date and place, a ion, death occurre	and due to the dead at the time, d	cause(s) and n date and place	nanner as sta , and due to	ated. the cause(s)
	To ti withi. To ti	W	29b. Signature and title of certifier	S V	MD.	29c.	License n	1738		29d. Date sign	ed (Month, E	Day, Year)
0	KDS		30. Name and address of person who co			Print)	DE	AN RD.	HOLL	,4W00)	o mi	0 20636
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire							

ORIGINAL

			For State Registrar	State of Maryla		ent of Health and ate of Death		giene (005	20261
	Dhysiai		1. Decedent's Name (First, Middle, La.				2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		Mahlon Frankli	Hutzel		100.00	06	09	05	12:25 PM
	Examin		4a. Facility Name (If not institution, give	1 41 1	4	City, Town, or Location of Dea	-0	4c. Cour	nty of Death	
		₹*		art Hespi		cert Werlav		A	116.90	
	Funeral Director		5. Social Security Number 214-16-2110 Usual Residence of Decedent	ex 7. Age (in yrs	Mon			1915	9. Birthp Coun Mary	lace (State or Foreign stry) land
	lanyland show		10a. State 10b. County	10c. C	ity, Town or Location				1	0d. Inside City Limits
	Man F-f sh	to	MD Garret	Gra	antsville	9				1 ☐ Yes 2 🕱 No
	th the	Director	10e. Street and Number		101	. Zip Code		10g. Citizen o	of What Coun	ntry?
	23a	ai	2680 Amish Road	E		21536		USA		
	r dea	Funerai	11, Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13. Was D If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. R	lace - Americ lack, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1 □ Y€	s 🄏 No Specify:		Spec	cify: T.71-	
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28a-f show ha Nadical Examinar manal be notified at	ed b	15. Decedent's Ed		16a. Decedent's	Isual Occupation		16h Kind of	Business/Inc	ite
15	in 72	olet	(Specify only highest gra	de completed)	(Give kind o	f work done during most of wo T use retired)	orking	TOD. KING OF	0001110001111	300119
212	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Labore	2		Const	truct	ion
	other vent,	0	17. Father's Name (First, Middle, Last,			18. Mother's Na	me (First, Middle,	Maiden Sum	ame)	
lar	Mental Merked o	ToB	Frank Hutzel			Ida Dı	ırst			
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (_	ress (Street and Number or F		-		
	1 and 2 Health em 27		Freda Hutzel/W			mish Rd., G				1536
ore	of H		20a. Method of Disposition 1		Place of Disposition cemetery, crematory			20c. Locatio		
Ë	Pages Iment of I Ient: If its jury or o		`4 ☐ Donation 5 ☐ Other (Specif	// Lai		emetery June				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Mydical Event erroratible in titles at any injury or other traumatic event, the Mydical Event erroratible in titles at any injury.		21. Signature of Funeral Service Licen	Euman	P.0	e and Address of Facility Box 275,	Grantsvi	ille,		mes, P.A. 21536
	Physician /Medical Examiner	ier	23a. Part1. Enter no disease, or conshock, or heard failure. List only Immediate Caus. Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury)		TMIOLE quence of): ATRIAN	CENETSRAL A FIBRILL		rest, STRO	KE	Approximate Interval Between Onset and Death 7 PAXS
,8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to {or as a conse	quence of):					
O. Box 6	he death certific / the attending p ched for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3 ☐Ectop	ic pregnancy r (specify)			Date of delive Month	ory Day Year
Records, P.	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underly	ng cause given in Part I.	23e. Did to	_/		ne cause of death? ably 4 □Unknown
COL	w requir been si should	iete					24a. Was a	an 24t	b. Were autor	psy findings available
Re	he lav e has	Completed					autop: perfor	med2	prior to cor death?	inpletion of cause of
Vital		Ö	25. Was case referred to medical			26 Place of De	1 ☐ Yes eath (Check only or	2 No	1 🗌 Yes	2 No
>	97 (0 =	0	examiner?	Hospital: 1 Inpatient 2[☐ ER/Outpatient 3F	Other	Home 5 Resid		ther (Specific	()
of	를 수 필	 -	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe h			"
ion	Attanding r death. ector: After y the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		M	1 ☐ Yes 2 ☐ No				
Division	al or Attano after death Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fa	ctory, office	28f. Location (S City or Tow		mber or Rura	l Route Number,
	To the Hospital or Attand within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 102 Certifying Pt (Check only one)	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death occunation and/or investiga	rred at the time, date and plac tion, in my opinion, death occ	e, and due to the curred at the time, o	ause(s) and date and place	manner as st e, and due to	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	0		29c. License number	2	29d. Date sign	ned (Month, I	Day, Year)
			> Trypy , n	y		D1092/		SUNE	9,	2005
			30. Name and address of person who VIRGINIA MAGIN	completed cause of death (Ite	em 23a) (Type, Print)	29c. Ligense number DT093/ SETON OPEN	E cum	Punis	4ND, V	100 2 KON
	Sta	ite ar	31. Date filed (Month Year)	32. Registrar's Sign		of a				

			1 - State of State of Registrar	Maryland / Depa	artment of F			0000	
			Decedent's Name (First, Middle, Last)		inoute or	Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physici /Medio		Genevieve Patric	ia Hess				Day Yea 31 200	r
	Examir		4a. Facility Name (If not institution, give street and num	ber)		r Location of Death	III S	4c. County of De	ath
			Frederick Memoria	al Hospital	Frede	erick		Frede	rick
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 9,	9. B	irthplace (State or Foreign Country) nnsylvania
	p ,		Usual Residence of Decedent						
	show	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Ne M	Director	Maryland Frederick	Frederick					1 ☐ Yes 2 ☐ No
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural" or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	٦	10e. Street and Number 816 Dunbrooke Court		10f. Zip Code 2170	1	10g.	Citizen of What (,
	death ms 2	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Spe	cify Yes or No-	14. Race - An	
ဖွ	after or ite	Ful	Armed For	Des? II Do No	Yes, specify Cuba	an, Mexican, Puerto I	Rican, etc.)	Black, Wh	
8	ural',	d by	3 Middwed 4 Divorced Year or Da	tes:	☐ Yes 2 No	Specify:		Specify:	White
2	"nat	lete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup	ation during most of workir d)	ng 16b	. Kind of Busines	s/Industry
21215-0036	withi	Completed	Elementary/Secondary (0-12) College (1-	40r 5+)	Homemake:			Own Ho	me
0	filed Hygi other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid		
Maryland	12 should be fi n and Mental H 7 Is markad ot raumatic ever	To B	David Guise			Mary Gene	evieve Ros	sensteel	
ary	d 2 should th and Men 7 Is marka traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	l Route Number, Cit	y or Town, State,	Zip Code)
	os 1 and 2 of Health item 27 other tra		Deborah Keller (Daughter	:) 43 Ha	tteras Si	treet, Oce	ean Pines	, Maryla	nd 21811
ore			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from S	20b. Place of Dispos	atory or other plac	e)		Location - City of	
Baltimore,	: Pag tment tant:		' 4 □Donation 5 □ Other (Specify)	Smithsour					, Maryland
Ba	parmit. Page Department of Important: If any injury or		21. Signature of Funeral Service ticen	R8	BERT ^{end} E ^{Addre} i	SATLEY & S MARKET ST	ON FUNERA	AL HOMES	, P.A.
			23a. Part1. Enter the disease, or complications that each shock, or heart failure. List only one sause a			g, such as cardiac or		CICK, FID	Approximate
	nysician			hero sclenotic	Card	10 VALCULAR	Disease		Interval Between Onset and Death 40 7 enns
	/Medical		resulting in death)	r as a consequence of):		14 0 14 12 11 14 12	12011	_	Togening
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	sit sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	r as a consequence of):					
	cate be axacuted physician and the burial-transit	Examin	that initiated events c.	r as a consequence of):					
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	flicate p physics the	edlcal	d.						
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מ	death	Physician/M	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
י כ	that the de led by the a detachad f	hys	9 ☐ Unknown 9 ☐ Unknow						
<u>'</u>	98	by	Part II. Other significant conditions contributing to dea	th but not resulting in the un	derlying cause give	en in Part I.			to the cause of death?
010	been sig	eted					1 Tes	2 □ No 3 □ P	robably 4 Unknown
Kecords	has by	ompleted					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
_ '	icate ha	0					performed?		s 2 No
Vital	Physician: The law this certificate has trail director, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 In	0000	3□ DOA Othe	26. Place of Death			
0	E E	\vdash	27. Manner of Death 28a. Date of		28c. Injury	at 2	ne 5 Residence 8d. Describe how in		ecify)
<u>.</u>	ath. r: Afte	atlo	1 Natural 5 Pending (Month, 2 Accident investigation	Day Year) Injury	Work M 1□	(? Yes 2 □ No			
UNISION	al or Attending Is after death. I Diractor: After d in by the funer.	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of building	f Injury - At home, farm, stre	et, factory, office	2	8f. Location (Street City or Town, Sta	and Number or R	ural Route Number,
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:	lo the hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and manner.	is of examination and/or inve	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
	Mithin To the	Me	29b. Signature and title of certifier		29c. License			ate signed (Mon	
			1/746- MD		Dog	75152		6.1.0	5
	n		30. Name and address of person who completed cause	of death (Item 23a) (Type, P	rint)	740)	
	/		J.L. Kranz, M.D.	100 S. Ce	nen Si	The	nont	MU 21	788
	Stat Registra		31. Date filed (Month, Day, Year) 32. Re JUN 0 3 2005	strar's Signature	Cook		•		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** June 2005 06:15 A M EDNA LILIEN HAMILTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 26, 19 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Director 1920 508-12-0621 South Dakota Usual Residence of Decedent death with the Maryland ahow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahov the Medical Examinar must be notified at 1√2 Yes 2 □ No Director MD Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 Windom Road 20722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ulvinen John Killinen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Trezise, Daughter 1900 Corbridge Lane, Monkton, Maryland 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 06/07/05 Brentwood, Maryland 21. Signature of Funeral Pervice License 22. Name and Address of Facility Gasch's Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one gause on each line. 4739 Baltimore Ave., Hyattsville, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonary Embolism disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** <u>Coronary Artery Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injured exerts.) Due to (or as a consequence of): Examine nding physician and use as the burial-transit certificate be executed Carotid Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter 3 Ectopic pregnancy ō Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2X No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\subseteq No 1 Yes 20 No Yes Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2√ No 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; or Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C Hospital 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46998 tun Tuc June 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamilton Street, Suite #1, Hyattsville, Maryland Steven T. Tee, MD 31. Date filed (Month, Day, Year) State JUN 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** William T. Hill May 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico 4001 Grosse Point Drive Salisbury If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Months Min Hours 1 XM 2□F Yrs 70 Director 214-32-1081 March 4,1935 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Evanticar must be political at 1 √ Yes 2 □ No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 Grosse Point Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nort of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Hill Myrtle Walker ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean Hill/Wife 4001 Grosse Point Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 6 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. June1,2005 Salisbury, MD Wicomico Mem. Park * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Lervice/Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, MD 21840 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final Physician ancres tre Cance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death ed by the a signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 No 2 No the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manper of Death 28d. Describe how injury occurred Certification; 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation efter deatl Director: 6 Could not be determined n 24 hours efter de ne Funeral Directo pletely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the and title of certifie License number 29d. Date signed Month, Day, Year) 29b. Signatu 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David H. Smith 6602 Church Hill Rd., Chestertown, MD 31. Date filed (Month, Day, Year). State

DHMH 17 Rev 1/2001

Registrar

JUN 0 3 2005

			1 - For State Registrar	State of Ma	aryland		artment rtificate					iene 2 ()	05	20265
	Dhysisi	an	1. Decedent's Name (First, Middle, La.	,						2	. Date of Deat Month		Year	3. Time of Death
	Physici /Medic		LILLY EI	IZABETH	HOLS	EY					MAY 2	0, Day 200	5	9:07 AM
	Examin		4a. Facility Name (If not institution, giv-			_			Location of			4c. County		
			Manor Care C				1 .			Sprin	.g	MON		MERY
	Funeral Director		5. Social Security Number 218-56-8375 Usual Residence of Decedent	ex 7. Ag □M 2⊠F	76	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min. M	Date of Birth (Month, Day, ay 7,	^{Year} 1929	9. Birthp Cour Mal	place (State or Foreign http:// ryland
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits
	Many -1 sh	ğ	MD Monto	omery		P	otoma	ac.						1 ☐ Yes 2 ☐ No
	r 28e	Je C	10e. Street and Number				10f. Zip	Code			10	Og. Citizen of W	/hat Cour	ntry?
	h with	al D	7814 Scotla	nd Drive	<u> </u>			2	0854	1		U.S	.A.	
9	7.72 hours after death with the Maryland "naturel", or Itams 23a or 28e-1 show caffed Exertified or 1881 by Invitiled at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give		1	Was Deced				fy Yes or No- can, etc.)		k, White,	ean Indian, etc. lack
5-0036	urel',	d by	Widowed 4 ☐ Divorced	Year or Dates:										
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	ba filed within tal Hygiene. Ind other than event, Its M	e Co	17. Father's Name (First, Middle, Last)				Juber	VIIC		er's Name (F	First, Middle, N	Maiden Sumame		
Maryland	should ba ind Mental s marked o umatic eve	To Be	Nelson Coop	er						Milo	y Car	roll		
Mai	id 2 sho lith and 27 is ma trauma		19a. Informant's Name/Relationship (Courtney Gibbs	• • • • • • • • • • • • • • • • • • • •			_					City or Town, S		
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	/Medical Examiner		resulting in death)	Due to (or as	a poseque	n of)		1	/ ,					1 0
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rds, P.O.	w requires that to been signed by should be detained	by	Part II. Other significant conditions of	ontributing to death b	out not result	ing in the u	nderlying ca	ause give	n in Part I.			acco use contri s 2 □ No		ne cause of death?
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ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Magnital				- 01		of Death (C	Check only one	9)		
	Physi this c	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie		R/Outpatier		mara.	4 Certau			nce 6 Othe		y)
35	ng ftei ne	lon	27. Mann of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year) 2	8b. Time of Injury		Bc. Injury Work			d. Describe ho	w injury occurre	ed	
35	uttendi death. ctor: A / the fu	icat	2 Accident investigation 3 Suicide 6 Could not b	A	une At hom	a form sta	M		'es 2 □ !	_	Location (Str	not and Mumba	a o a Duan	I Route Number,
Division	or A after Direc in by	Certification;	4 Homicide determined	28e. Place of Inju- building, et	c. (Specify)	ie, iaim, str	eet, ractory,	, опісе		201	City or Town,		ir or mura	i rioute Number,
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Co	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis of and manner sta	f examinatio	edge, deatl on and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, and th occurred	due to the ca at the time, da	use(s) and mar te and place, a	nner as st	tated. the cause(s)
	To thi within Fo the	Me	29b. Signature and title of certifier				29c.	. License	number		29	d. Date signed		
	- 2 F 0) CLA	AN			T.	160	128	1		5/2	-11	OF
•	V		30. Name and address of person who				Print)				71	-1	D.C.	20070
			Ishiaq Malik, 31. Date filed (Month, Day, Year)						. #3 ₋	10, W	asnin	gton,	שט	ZUUTU
	Sta Registr		JUN 02	2005	ar's Signatur	4 A	park	9						

			1 - For State Registrar	State of Marylan				and M	ental H	ygiene	Eogibie		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death		2. Date of D	Reg. No	·200	C O	me of Death
	Physici	an			L-	Lunn	00	9	Month	2 Da	_		A M
	/Medic Examin		EDWARD 4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location o	of Death	_\$. County of De	eath	
	Examin	ęr	MANOR CARE.	Λ		Potomac					fontgom		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under:	24 Hrs.	8. Date of E	$\overline{}$	9 B		tate or Foreign
	Director		000 10 3403	M 2□F 98	Yrs.	Months Days	Hours		July				k, N.Y.
	pur *		Usual Residence of Decedent 10a, State 10b, County	10c Cit	y, Town or Lo	cation						10d Insid	de City Limits
	Aaryla f sho	៦											Yes 2 □ No
	the P	rect	Maryland Montgomer 10e. Street and Number	y Po	tomac	10f. Zip Code			-,	10g. Ci	tizen of What	Country?	
	3a or	Funeral Director	8709 Hickory Bend	Trail		20854				II.	S.A.		
	deat	ner		12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Was Decedent of f Yes, specify Cub		gin? (Spec	cify Yes or N	1	14. Race - An Black, Wi		an,
98	or Its	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		Yes 2X No		i, i deito i	noari, otc./		Specify: W		
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jigal Evat. It wit must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	1 40 5	1				1 101 11			
15-	"nat	Completed	15. Decedent's Edu (Specify only highest grade		(Give	lent's Usual Occu kind of work done DO NOT use retire	during most	t of workin	1g	16b. K	and of Busines	ss/Industry	
12	within ione.	omp	Elementary/Secondary (0-12) 8th Grade	College (1-4or 5+)	Banke		/			Fi	nancia	1	
D	be filed within 72 hours after death with the Marylan Ital Hygiene. It other than "natural", or Itams 23a or 28a-f show avant, the Medical Evac, il retrinal be notified at	Be C	17. Father's Name (First, Middle, Last)		Danke		18. Mothe	r's Name	(First, Midd			<u></u>	
<u>lar</u>	should be nd Mental markad c	To B	Edward W. Hummer	S			F1c	orenc	e Yat	es			
Maryland	2 should and Men is marka		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Stree	t and Numbe	r or Rural	Route Num	ber, City	or Town, State	, Zip Code)	- 3
	is 1 and 2 should of Health and Men itam 27 is marka other traumatic.		Edward W. Hummers			Hickory	Bend						
Baltimore,	Ges 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	emetery, cren	sition (Name of natory or other pla			ete		ocation - City o		
Itim	riant.		' 4 □ Donation 5 □ Other (Specify)			rt Crema							
Bal	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service License	R		Name and Addr							
-3			23a. Part1. Enter the disease, or compli	cations that caused the deat		130 Wisc					ing Lon	Approx	cimate
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final		.10			10.					and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	LULA	2 1	_ \rangle 3 (W	cie	n cy	-2	TRS
В	Examiner		Sequentially list conditions).							L		
	p =	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uanas at):							-	
8760,	cate be executed physician and the burial-transit	Ical E		Due to (or as a conseq	derice oi).								
687	phys phys s the			1					-				
Box (leath certific attending p I for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna							23d. Date of d	elivery	
	death certifica e attending ph od for use as th	icla	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		Ectopic pregnand Other (specify) _	cy				Month	Day	Year
P.0	by the a	Physiclan/Med	9 🗆 Unknown	9Ll Unknown									
	as the	by P	Part II. Other significant conditions con								use contribute		
Records,	w require been sign should t	Completed	WALT-IN	FARCT	De	ner T	IA		1	Yes 2	M2(No 3□1	Probably	4 ⊟Unknown
ec	e law I has b	nple								opsy	prior to	o completion	ings available of cause of
E H	Th ate pag	Cor							1 ☐ Yes	formed? 2 No	death		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	55.0	Ot			(Check only				
of		: To	1 Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of	1 3L DOA	4 A NU		8d. Describ		6 □Other (Sp ry occurred	ecity)	
ion	= = =	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2.∏l	No					
Division	Attandi er death. actor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office)	2		(Street ar	nd Number or i	Rural Route	Number,
	ital or rs afte al Dir	Cer		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									9
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina									15e(s)
	To the within 2 To tha complet	Med	29b. Signature and title of certifier	and manner-stated.		29c. Licen	ise number			29d. Da	te signed (Mo	nth, Day, Ye	ear)
	or with		Dict - and	th toll-	rie	0 0	295	フー	7	5	-28	-06	
7	4		30. Name and address of person who co	empleted cause of death (Item	n 23a) (Type.	Print)		۷ (Va	1181	~~~
			0 0 11 0	LEP ME	> (c	Print)	Copy	RET	ccut	Ave	- a	102	0/97
	Sta		31. Date filed (Month, Day, Year)	Hegistrar's Signa	ature Ang	de							7.3
	Regist	aı	JUN 03 200	3 Elementes Jo	19								

			For	State of Maryland			ental Hygie	ne) 0 0 5	20267
			Registrar 1. Decedent's Name (First, Middle, Las	54)	Certificate of	Death	Reg. 2. Date of Death	No.	2 Time of Death
	Physici		Flinh F H	at Ir			Month A	Day Year	3. Time of Death 9.30 PM
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death	May a	4c. County of Death	
			1234 Crows	nest Court	Ann	apolis		Anne +	trundel
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Ye		nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	5.7	113.		Oct. 29/19	747 IVIC	ryland
	nyland thow		10a. State 10b. County	10c. City, 1	Town or Location				10d. Inside City Limits
	8e-f	ecto	Manyland Anne -	Arundel A	nnapolis				1 Pres 2 No
	with ti	Dire	10e. Street and Number	+ 1 +	10f. Zip Code	12	10g.	Citizen of What Cou	untry?
	death ms 23	Funeral Director	1234 Crowsn	12. Was Decedent Ever in U.S.	13. Was Decedent of H	dispanic Origin? (Spec	cify Yes or No-	14. Race - Amer	
9	or Ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	If Yes, specify Cub	an, Mexican, Puerto F Specify:	Rican, etc.)	Black, White	1 1
21215-0036	72 hours after death with the Maryland netural', or Items 23e or 28e-f show disal Examirer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:				Specify: BI	ack
7	in 72 n "net	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working d)	ng 16t	b. Kind of Business/I	ndustry
212	filed within Hygiene. other then "	, mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Park and R	ecreation	ca/ 5	state 6	overnment
	be file ital Hy id othe event,	BeC	17. Father's Name (First, Middle, Last)	4		18. Mother's Name	(First, Middle, Mail	den Sumame)	
yla	should be nd Mental marked o	^L	Elijan E, Hur	il, Sr.		trelyn	Care	/	
Maryland	0 0 0 0		19a. Informant's Name/Relationship (ype, Print)	19b. Mailing Address (Street	and Number or Rural	Route Number, C	ity or Town, State, Zi	ip Code)
	s 1 and 2 f Health item 27 i		20a. Method of Disposition	000	ce of Disposition (Name of nefery, crematory pr other pla		ate 200	c. Location - City or 1	Fown, State
Ë	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	Facto Memoria	10/3/	65 7	Innapoli.	s, MD
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of		21 Signature of Funeral Service Licen	kee //	22. Name and Addre	ess of Facility		_ /	1
_	205 29		felled the		Niller's Me	tropolitano	Chapt 193	W-Forest L	x. Annapolis Mi
H			23a. Fart1 Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that caused the death. I	Do not enter the mode of dyir	ng, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Welkel	elle Car	reg			
	Examiner		O constallation florida and distance	Carena	wa ofth	1 ton	ut		
	ם #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):				
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequen	200 of):				
8760,	icate be executed physician and s the burial-transit			Due to (or as a consequer	100 01).				
9	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical		_d					
Вох	leath certifica attending ph d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	y eath 3 Ectopic pregnancy	v.		23d. Date of deliv	,
	that the death ned by the atter detached for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□Unknown		,		Month	Day Year
О. О.	that th		Part II. Other significant conditions or	ontributing to death but not resulting	ng in the underlying cause giv	ven in Part I	23e. Did tobacı	co use contribute to	the cause of death?
Vital Records,	The law requires that the to be a signed by the bas been signed by the bage 2 should be detache	d by	•		and and any mg daddo g		1 Yes		bably 4 Unknown
CO	w req	lete					24a. Was an	24b. Were aut	opsy findings available
Be	The lav	Completed					autopsy performed	death?	ompletion of cause of
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death		110	
	Physicien: r this certificatal director, I	은	1 ☐ Yes 2 ☐ No		VOutpatient 3 □ DOA Oth	4 Nuising Hon		e 6 □Other (Speci	ify)
on (ding F h. After funer	tlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Bb. Time of 28c. Injury Wor	yat k? Yes 2 □ No	8d. Describe how i	njury occurred	
Division of	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home				t and Number or Rur	ral Route Number,
á	tel or A s after el Direc ed in by	Certification:	4 Homicide	building, etc. (Specify)			City or Town, S.	tate)	
	Hospi 4 hour Funer ely fill	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowle niner: On the basis of examination	edge, death occurred at the tire and/or investigation, in my o	me, date and place, a	nd due to the cause	e(s) and manner as	stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Eunerel Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens			Date signed (Month,	
)	F 3 F 8		Caration	Harris	MA	15230	6	5/2/	112 1
	//		30. Name and address of person who	completed cause of death (Item 2:		//) / *		1///	105
			Curtes Harris			Sto 211 1	Annapol	15, MD	214 01
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature				1	•
	- riegisti	21	JUN 0 1 20	U) AND AND AS					

State of Maryland / Department of Health and Mental Hygiene

			1 - For Stata Registrar		State of W	arytariu /		rtificate of	Death	vientai i i	Reg. N		pina spila	
	Physici	an	Decedent's Name (First, M.	fiddle, La	ast)					2. Date of D Month		ay	Year	3. Time of Death
	/Medic		JOHN			WIN				MAY	30	20	005	11:10P M
	Examin	ier,	4a. Facility Name (If not instite COLLINGTON)		4b. City, Town, MITHCEL	or Location of Deatl	h		RINCE		RGES
	Funeral Director		5. Social Security Number 070–20–1189		Sex 7. An 1. X M 2□ F	ge (In yrs. last 80	birthday, Yrs.	Months Days		8. Date of B (Month, D JULY 1				place (State or Foreign NX, NY
	pu * ==		Usual Residence of Deceder 10a. State 10b. Co			10c. City, To	own or I	ocation						0d. Inside City Limits
	ie Marylan Ba-f show	ctor	MD PRIN	-	EORGES			VILLE						1 ☐ Yes 2X No
	th with the 23a or 2	Funeral Director	10e. Street and Number 10450 LOTTSF	ORD	RD. #2110)		10f. Zip Code 207	21		_	S.A.	Vhat Cour	ntry?
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show on the traumatic avent, the Medical Eval it without the Indiff of a control of the traumatic avent, the Medical Eval it without the Indiff of a control of the Indiff.	by	11. Marital Status 1 □ Never Married 2 ☆ 3 □ Widowed 4 □ Divo		12. Was Decedent Armed Forces 1 Yes 34 If Yes, Give Year or Dates:	? No	13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert o Specify:	pecify Yes or No Rican, etc.)	0-		k, White,	
5-0	72 ho 'natur	Completed	15. Dec	edent's E	ducation rade completed)	1	(Give	dent's Usual Occu	a during most of wor	rking	16b.	Kind of Bu	siness/In	dustry
121	within ene. than	mpi	Elementary/Secondary (0-	12)	College (1-4or	5+)		DO NOT use retire	•		F	EDERA	L GO	VERNMENT
d 2	filed Hygie ther	ပို	17. Father's Name (First, Mic	ddle, Las	5				18. Mother's Nar	ne (First, Middl	e, Maid	en Sumam	e)	
Maryland	outd be Mental arked o	To B	JOHN IRWIN						MARGAR	ET CRAV	EN			
ary	2 should and Men is marke aumatic	-	19a. Informant's Name/Rela	tionship	(Type, Print)	1	9b. Mail	ing Address (Stree	at and Number or Ru			or Town,	State, Zip	Code)
	and 2 ealth a n 27 is		BRIDGET IRWI	n/wi	FE	1	0450	LOTTSFO	RD RD. #2	110 MIT	CHE	LLVIL	LE,M	D 20721
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong.		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Oth	tion 3 (☐Removal from State	ceme	atery, cre	osition (Name of matory or other pla OLN CREM	ATORY6/3/	Date 05		Location -		
alti	permit. Par Department Important: any injury once.		21. Signature of Funeral Ser				2	2. Name and Addr	ess of Facility AI	NES RIN	ALD	I FUN	ERAL	HOME
Ö	Depar Impo any ir		Kenya	Otev	part		Ī	1800 NEW	HAMPSHIR	E AVE.	SIL	VER S	PRIN	G.MD 20904
	JER.		23a. Part1. Enter to seas shock, or heart failure. Immediate Cause (Final	e, or cor List only	mplications that cause y one cause on each	ed the death. E line.								Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	-		IMER S		ASE					-	3 YRS.
	Examiner							DISEASE						3 YRS.
		je.	Sequentially list conditions,		Due to (or a	s a consequen	ce of):							
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	c CONGES	STIVE B	EART	FAILURE						2 YRS.
oʻ	e exe		resulting in death) Last		Due to (or a	s a consequen	ce of):							
68760,	tificate be executed ig physician and as the burial-transit	Medical			d. PARKII	SON'S	DISE	ASE						2 YRS.
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			e of pregnancy 2 Fetal de at time of death	ath 3	☐Ectopic pregnand ☐ Other (specify)	су			23d. Date Mor	e of delive	ery Day Year
Θ,	res that igned b	by PI	Part II. Other significant con	nditions	contributing to death	but not resultin	g in the	underlying cause g	iven in Part I.	23e. Did	tobacco	o use contr	ibute to t	ne cause of death?
rds	w require been sig should b	ed b								1 [Yes	2 X No	3 🗌 Prot	ably 4 Unknown
Records,	The taw re	Completed			 					per	opsy formed?	, 8	Vere auto prior to co leath?	psy findings available mpletion of cause of
Vital	(0	a	25. Was case referred to me	dical					26. Place of Dea	1 ☐ Yes ath (Check only		10	- 163	20110
Į (Physician: this certificated ral director,	To B	examiner? 1 Tes 2 No		Hospital: 1 🗌 Inpat	ient 2□ER	Outpatie	nt 3 DOA	ther: 4X Nursing H	lome 5□Res	sidence	6 □Othe	er (Specit	y)
ion of	ding After fune			ending vestigati	28a. Date of Inj (Month, D	ury 28 ay Year)	b. Time o Injury	W	ury at ork? ⊒Yes 2 ⊒No	28d. Describe	how in	jury occurr	ed	
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ C	ould not etermine	d 286. Place of It	njury - At home atc. (Specify)	, farm, si	treet, factory, office	•	28f. Location City or To			er or Rura	il Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funaral Director:	Medical C			Physician: To the besiminer: On the basis and manner s	of examination								
	To the within comp	×	29b. Signature and title of ce	ertifier	lecurp	al-l	. Ич.		142049			AY 31		
	4		30. Name and address of pe		K, M.D. 1	4314 OL	D MA	ARLBORO P	IKE UPPER	R MARLBO	ORO,	MD 2	0712	
	Sta Regist		31. Date filed (Month, Day,	Year)		trar's Signature								
			0011 0	<u>, _,</u>	No. of the last		/							

			, 101	artment of Health and Me ertificate of Death	ntal Hygiene	5 20269
	Dhusisi		Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year	3. Time of Death
	Physici /Medic		Genevieve Ingle		une 11 2005	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
			6822 Potomac Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Braddock Heights If Under 1 Year If Under 24 Hrs. 8	Frederi	CK.
	Funeral Director		5. Social Security Number 5. Sex 1 → M 2 M F 93 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year) an. 25,1912 Mar	ountry) Cyland
			Usual Residence of Decedent			
	rylan ihow		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	Ba-f s	cto		K Heights		1X Yes 2 □ No
	vith th	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
	s 238	ra E	6822 Potomac Avenue 11 Marital Status 12. Was Decedent Ever in U.S. 13.	21714	USA v Yes or No- 14. Race - Am	orican Indian
	Itam Itam	-un-	11. Marital Status 1 Never Married 12 Married 12 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 15 No Sale Miles	Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Richard Control Programme Control Program	an, etc.)	
336	urs af	by	3 X Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: W	nite
215-0036	within 72 hours after death with the Maryland ane. than 'natural', or Itams 23a or 28a-f show 's Marical Ext. citter it ust be malled at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working	16b. Kind of Business	s/Industry
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	filed wi Hygien sther th	Con	12 4 Medica	al Records Librarian		ernment
and	iould be fil Mental H narked ott natic avan	Be	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Sumame) e Alice Farsht	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importament of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, it is Marical Examinal must be mailtied at once.	Jo		ing Address (Street and Number or Rural R		Zin Code)
Ma	d 2 sl th and 17 is r traur			Palmer Road, Middle	· ·	
	1 and Health Iam 27		20a Method of Disposition 20b. Place of Disp	osition (Name of Date		
Baltimore,	Pages nent of I int: If its ury or o		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Smithsbu	rg Crematory $6-13-20$	005 Smithsburg	, Maryland
Ħ	artme ortan injur			22. Name and Address of Facility	504 Main Stre	
B	permit. Departr Importa any inji		Pater Lycipile	icketts Funeral Home	e Myersville, M	D 21773
			23a. Part1. Enter the disease or complications that caused the death. Do not en shock, of heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. COPD: Brown resulting in death)	chiectasts		Onset and Death
	/Medical		Due to (or as a consequence of):	2		- 900
١.	Examiner			Bilelan (495		2 weeks.
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			1 400 1
V	ecute and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			i runth
8760,	cate be executed physician and the burial-transit	ical E	DVT			2 weeks. 1 Months
687	requires that the death certificate be executed een signed by the attending physician and nouid be detached for use as the burial-transit	adic	d			
Box (eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	elivery
Ď.	death e atte d for	icia	in the past 12 months? 1 Yes 2 No 1 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month	Day Year
P.0	that the de sed by the a detached f	hys	9 Unknown			
	uires that signed t Id be det	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute t	
ord	w require been si should b	ted	DM II, Ataial fibrilation		1 Yes 25 No 3 P	robably 4 Unknown
ecords,	≥ □ 🕏	Completed			autopsy prior to	utopsy findings available completion of cause of
R	The ate ha	Con			performed? death? 1 Yes 2 Yo 1 Yes	s 2 No
Vital	ding Physician: The lav h. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?	26. Place of Death (C		
of	Physic this c	၉	1 Tes 2000 1 Inpatient 2 EH/Outpatie		esidence 6 Other (Specific Describe how injury occurred	ecify)
OU.	ding P. h. After t funera	lon	27. Manner of Death 1 Shatural 5 Pending (Month, Day Year) 1 Accident investigation	of 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	a. Describe now injury occurred	
Division	or Attending ifter death. Director: After in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si		. Location (Street and Number or F	Rural Route Number,
Di	after after Dine d in b	Certification:	4 Homicide building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the			th occurred at the time, date and place, and	due to the cause(s) and manner a	s stated.
	ha Ho in 24 ha Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date and place, and du	e to the cause(s)
	To tha by within 2. To tha I complet	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
			- comes Il	216-10	6/13/0))
	15		30. Name and address of person who completed cause of death (Item 23a) (Type		arvland 21701	
		, to	Martha J. Pierce, M.D., 300 W 9th S		rryrand 21/01	
	Sta Regist		JUN 1 7 2005			

	∆MENT.	₩19	State of Maryland / Department of Health and Mo SperFH6/3/05, BM, McCo Certificate of Death	, ,	jiene leg. No. 200	5 20270
	Physic		Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
-	/Medi	cal	Martha Bell Jackson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	may	31 2009 4c. County of D	2 1050
7	Exami	ner	7600 Maple Are #506 takona	Park	1	onery
	Funeral Director		5. Social Security Number 170-28-1987 6. Sex 1	8. Date of Birth (Month, Day APTILIS)	Year) 9. E	Birthplace (State or Foreign Country)
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	•		10d. Inside City Limits
	e Mary Sa-fah	ctor	Md montgomery Taxama fork			1 X Yes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 7600 Maple Ave 10f. Zip Code 20903		10g. Citizen of What U.S.A	Country?
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show miny injury or other traumatic event, the Medical Examiner must be notified at once.	à	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? □ □ No If Yes, specify Cuban, Mexican, Puerto R If Yes, Specify: 13. Was Decedent of Hispanic Origin? (Specify: Upan, Mexican, Puerto R If Yes, Specify: 1 □ Yes 2 ₺ No Specify: 1 □ Yes 2 ₺ No Specify:	cify Yes or No- Rican, etc.)		merican Indian, hite, etc.
15-0	n 72 h "natu	letec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng	16b. Kind of Busine	ss/Industry
212	d withii giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) U/KNOWN		UNK	NOWN
Maryland	ould be filed Mental Hygi arkad other atic event,	To Be C	17. Father's Name (First, Middle, Last) William H. Jackson 18. Mother's Name Laura H.	(First, Middle, I loren	Maiden Surname) Ce Brook	<u>\$</u>
	and 2 sho salth and 1 127 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Kulik I, Tackson (Sister) 19b. Mailing Address (Street and Number or Rural 6143 64 Thave Apt 3			d. 20737
Baltimore	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Grand View CemeTery		20c. Location - City Southmen	or Town, State TBOTO, POL. HOME + Cremitan
Balt	permit. Pag Department Important: I any Injury o	ka. 9	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cha Thomas 5. Chamb 5801 Clevel and Ave. 1	Rivera	Funeral	Home + Cremiter
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final			Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			ime
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ó	an and rial-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Вох	v requires that the death cer been signed by the attendin should be detached for use	ician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	02h Did to	basa was sentrib.	Ite to the cause of death?
P.O.	at the c by the stached	Phys	Part is Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Probably 4 Unknown
	res the signed I be de	ρ				No.
Records,	law requi	Completed		24a. Was a perforr	n autopsy ned?	 Were autopsy findings available prior to completion of cause of death?
alF	n: The icate l			1 □ Ye		1 ☐ Yes 2 ☐ No
₹	siciar certif directo	To Be	25. Was case referred to medical examiner? 1 ★ 2 □ No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 26. Place of Death of	STREET	ence 6 ⊟Other (S _i	200(64)
n of	ig Phy ter this neral c				ow injury occurred	oedily)
Division of Vital	tendir Jeath. tor: Af the fu	catic	2 Accident investigation M 1 Yes 2 No	04 Lanation /C4	turned and Alexander and	Dural Paula Musahan
Divi	al or At s after or il Direct ed in by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town		Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	Vithing to the thing the things of the thing	¥	29b. Sonature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number		9d. Date signed (Mo	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 (met.co.	D Pair	E Dr	2
	Sta Registi		JLH N BRECHER MO OME SILVEY SPULT 31. Date filed (Month, Day, Year) JUN 0 3 2005 32. Registrar's Signature)	0 5030	7
			page - 17			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Dorothy E. Jefferis May 30. 2005 3:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forest Glen Skilled Nursing Center Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Sept. 7, 192: If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 21 □ F Min. Months Days Hours 578-22-6854 81 Washington, DC Director Sept. 1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2700 Barker Street 20910 or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. I □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Specify: White 3 XWidowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If item 27 Is marked oth y injury or othar traumatic evant Guy William Lowd Martha Elizabeth Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Carroccio/ Guardian 107 West Jefferson Street, Rockville, MD 20850 Date 2, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 1 Deurial 2 Cremation 3 Removal from State Department of Important: If Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2005 Silver Siring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Myocardial Infarction Sudden /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Calles (Diseases of man that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the ! IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death the P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, eq Dementia 3 Probably 4 Unknown Ž-□ No director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \subsection Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 5 Pending investigation 1 🗷 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO0535 700r 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daphna Henkin, MD 2309 Shorefield Road, Wheaton, MD 20902

Registrar

State

31. Date filed (Month, Day, Year)

JUN

03

2005

32 Registrar's Signature

The said

.1			1 - For State Registrar		State of	f Marylar		artment e rtificate			and M	ental Hy	giene	2111	05	202	72
	0		1. Decedent's Name (First, Mid	die, Last)								2. Date of Do Month	eath Da	ıv	Yeer	3. Time of D	Death
	Physici /Medio		Virginia	. L.	Jeffre	у						May 29		<u>005</u>		20:20	М
	Examin		4a. Facility Name (If not instituti	_	street and nun	nber)		4b. City, To	wn, or	Location of	of Death		}	. County			
			Suburban Hospi			7 (12	In a A binds of a 1	Bethe		if Under:	24 Hrs. 1	0.0-460		lont	gomer		-
п	Funeral Director		5. Social Security Number 218.52.8717	6. Sex	M 2021F	7. Age (In yrs. 81	Yrs.		Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year)) 2 2	Cour	,,	_
			Usual Residence of Decedent			01					<u></u>	Dec. 31	. 15	123	wasn	ington	, DC
	ylang		10a. State 10b. Coun	ty		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City	
	Ba-f s	cto	MD Mont	gome	ry		North	Bethes	da							1x∑XYes 2	2 [] No
	or 24	Dire	10e. Street and Number					10f. Zip C					10g. Ci	tizen of V	Vhat Cour	itry?	
	s 23s	Funeral Director	10500 Rockvill			02 edent Ever in U	C 42	2085			-:-0 /0	-3	_ 1		S.A.	an Indian,	
	Item de	-un	11. Marital Status 1 □ Never Married 250Mi		Armed Fo	rces?	.5.	was Deceder If Yes, specify	Cuba	n, Mexican	gin? (Spe i, Puerto i	cify Yes or N Rican, etc.)	0-		k, White,		
920	urs af	by	3 ☐ Widowed 4 ☐ Divorce		If Yes, Giv Year or Da	/e		1 ☐ Yes 2√x	No.	Specify:				Specify	·: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f show the Medical Examinar must be notified at	Completed	15. Decedi (Specify only high				16a. Dece	dent's Usual (Occupa done d	tion	t of worki	na	16b. K	(ind of Bu	ısiness/Ind	dustry	
2	ithin se.	nple	Elementary/Secondary (0-12		2 College (1	-4or 5+)		kind of work DO NOT use omemak		ing mos	0. 110.11.	··y		Otate	n Hom	۵	
12	led w lygier her th		47 Fatharia Noma (First Middle)	- (000)			1			10 Matha	de Nome	(Final Adiabate	Maida				
and	htal Hed of the other	Be	17. Father's Name (First, Middle Ernest Elvin		017							<i>(First, Middle</i> Iarie H					
Maryland	thould the Me mark metic	ဥ	19a. Informant's Name/Relatio				19b. Maili	na Address (S	Street a			I Route Numb				Code)	
Σ	Ith ar 27 ie r treu		William Jeffre			on		-				er, CO	-				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show among injury or other treumetic event, the Medical Examination at the notified at anote.		20a. Method of Disposition			20b. I	Place of Dispo	sition (Name	of er place	9)	D	ate	20c. L	ocation -	City or To	wn, State	
E	Se in Se in		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		Removal from	State Mt.	Comfo	rt Cre	mat	őry. Jι	ine 2	2, 2005	A1	exar	ndria	, VA	
alti	rmit. poartir porte y inju		21. Signature of Funeral Service	e Licens	ee O		22	2. Name and	Addres	s of Facilit	y Jos	seph Ga	wler	's S	Sons,	Inc.	
<u> </u>	89 = 29		Willway	X.	Desig	W-						NW Wa		igtor	n, DC	20016	
г			23a. Part1. Enter the disease, shock, or heart failure. L	or compli ist only or	ications that c ne cause of e	aused the dea ach line.	th. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Betwee Onset and De	een
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	/Medical Examiner		resulting in death)			rdial I		er et e									
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9	rtifica ng ph as th	Physician/Medical	JF FEMALE:	-1													
Вох	death certific e attending p d for use as l	an/	23b. Was decedent pregnant in the past 12 months?	2		come of pregn		Ectopic preg	nancy					23d. Date Mor	e of delive	*	ear ear
о <u>.</u>		sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	4□ Pregn 9□ Unkno	ant at time of o	death 5	Other (spec	ify)					14101		Day 16	yea.
<u>P</u>	t t		Part II. Other significant cond.	itions cor	ntributina to de	eath but not res	sulting in the u	nderlying cau	sa giva	n in Part I.		23e. Did	tobacco	use contr	ribute to th	ne cause of dea	ath?
ds,		d by	Hyperlipidemi					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	J			1 🗆	Yes 2	⊠ No	3 Prob	abiy 4 □Un	iknown
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tal	icien: Th certificate rector, pag	Φ	25. Was case referred to medi	cal						26. Place	of Death	1 Yes	2√∑ No) 1	Yes	2 No	
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n of			27. Manner of Death 1 □Natural 5 □ Pene	ding	28a. Date (of Injury th, Day Year)	28b. Time o	f 28c	. Injury Work	at ?	2	28d. Describe	how inju	ry occurr	ed		
Sio	Attending r death. ector: After by the fune	catio		stigation				М	2.6	′es 2 🗆	-						,
Division	l or Attendatter death	Certification;		mined	28e. Place buildi	of Injury - At h ng, etc. (Speci	ome, farm, sti fy)	eet, factory, o	office		1	28f. Location City or To			er or Rura	I Route Numbe	ər,
	Hospitel or At 24 hours after of Funerel Direc stely filled in by		29a. Certifier 1 🖟 Certif	vina Phy	sician: To the	best of my kn	owledge deat	h occurred at	the tim	e date an	d place a	and due to the	causels	and ma	nner as st	ated	
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)			1 Patric	· a	1	0//	1/6	D	213	92			June	1,	2005		
	(>		30. Name and address of person														-
			Patricia D. Ke						Rd.	Suit	e 11	1 Rock	vill	.e, M	D 20	354	
	Sta Registi		31. Date filed (Month, Day, Yea		15 Kal	egistrar's Sign	k dos	the									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician AMES 23:50 16 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
MAY 16, 2005 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F MARYLAN Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic evant, Ita Medical Examinar must be neithfied at 1 XYes 2 □ No **Funeral Director** MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number MICKHAM ROAD 21229 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after Yes 210 No f Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ρ Specify: BLACK 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. NEWBOR 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If itam 27 is marked oth y injury or other traumatic evan HRISTOPHER HNTHONY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DEAN AUDRA 544 SOUTH WICKHAM ROAD BALTIMORE MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
12 Burial 2 ☐ Cremation 3 ☐ Removal from State OCTOBER BACTMORE, MARYLAND 20c. Location - City or Town, State permit, Page: Department or Important: If is any injury or NEW CATHEDRAL CEMETHY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ne and Address of Facility ST AG NET HOALTH CARE
100 CATO ST NET HOALTH CARE
BALTIMORE, MACYLAND 21229 21. Signature of Funeral Service Licensee De Advan Jo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNKNOWN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 2 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 1 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funaral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

31. Date filed (Month, Day, Year)

29b. Signature

ARRABAL

ompleted cause of death (Item 23a) (Type, Print)

900 SOUTH CATON

29d. Date signed (Month, Day, Year)

Registrar

29c. License number

			For State Registrar	State of Marylar	-		f Health an	d Mental Hy	giene Reg. No. 005	20271
			Decedent's Name (First, Middle, L.)	ast)				2. Date of De		3. Time of Death
10	Physici		Mary Jan	e Johnsto	n			Month	6, 2005	11:35 a.m
	/Medio Examir		4a. Facility Name (If not institution, gi		11	4b. City, Tow	n, or Location of D	June	4c. County of Death	
1	Lamin		22820 Maple R	oad		Le	xington I	Park	St. Ma	rv¹s
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under 24	Hrs. 8. Date of Bir		place (State or Foreign intry)
	Director		189-30-0768	1□M 2@F 94	Yrs.	Months Da	ays Hours M	Feb. 24	1911 Ire	ntry) 1and
	pu ,		Usual Residence of Decedent	100 0	b. Tour sal					
	aryła shov	_	10a. State 10b. County		ity, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	Funeral Director		Mary's	Lex	ington				
	with ti	<u>i</u>	10e. Street and Number			10f. Zip Cod			10g. Citizen of What Cou	untry?
	s 23	rai	22820 Maple R		1.0		0653	0.10	United St.	
	er de Item	nu.	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ■ No	J.S. 13.	lf Yes, specify (of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - Amer Black, White	
36	Irs af	by F	3 ■ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🐼	No Specify:		Specify: Wh	ite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dissal Examinar must be rodified at	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Business/l	ndustry
215	within 73 ene. than "n	Completed	(Specify only highest gi	rade completed) College (1-4or 5+)	(Give	kind of work do DO NOT use re	one during most of stired)	working		•
212	d with giene ir than	EO	Elementary/Secondary (0°12)	1	Lice	nsed Pra	actical N	Nurse	Healthcar	e
	e filed Il Hygie other vant, tr	BeC	17. Father's Name (First, Middle, Las	t)				Name (First, Middle	, Maiden Sumame)	
<u>a</u>	Mental Mental arked o	To	Samuel Roulst	on			I	Elizabeth	Maghee	
Maryland	2 should and Men la marke aumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Str	reet and Number o	r Rural Route Numb	er, City or Town, State, Z	p Code)
_	rt 2 lib		Margaret J. Foyl	e / Daughter	22820) Maple	Road, Le	exington E	ark, MD 206	53
ore	0 0		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 [20b.	Place of Dispo cemetery, crea	osition (Name of matory or other	f place)	Date	20c. Location - City or T	own, State
Ĕ	Page nent o ant: If ary or		`4 □Donation 5 □Other (Spec	ify) _ Ge	orge Wa morial	natory or other ashingt Park	on 6-	-8-2005	lymouth Mee	ting. PA
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Pervice Lice		22	2. Name and Ad			l Funeral Ho	
m	20 5 2 8		Edward N. Brinsi	ield, Jr. MOO	052 22	2955 Ho			nardtown, MD	-
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the dea						Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	DOMONT	ia)					Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consec	wence of):	•				2040)
	Examiner		Conventingly, liet and distance	, Duner	toria	21on				25 in
	n +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (gral a gonsed	uence of):	1	^ >			
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	. review	ral '	VONCO	elan de	score		25yrs
Ö,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a consec	quence of):	An.	elande Desea			754
8760	ate b	Icai		d. Colore	me	neny	SCHOOL STORY	re		- ogs.
9	ng ph as t	Physician/Med	IF FEMALE:		0	-				
Вох	eath certific attending p for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Bectopic pregna	ancy		23d. Date of deliv	- /
	e des the at	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at time of o	death 5	Other (specify	')		Month	Day Year
P.0	at the de d by the a etached	Phy	9 Unknown							
	res that igned to be det	by	Part II Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause	given in Part I.		obacco use contribute to	
Records,	w require been si should I	Completed	aye					_ 1 🗆 '	Yes 2. PNo 3 □ Pro	bably 4 Unknown
e C	has b	pie	U					24a. Was	osv prior to co	opsy findings available ompletion of cause of
E .		Con						perfo	rmed? death? 2 ■ No 1 □ Yes	2 □ No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					Death (Check only o	one)	
of V	Physic this co	၉	1 ☐ Yes 2 ☑ No		ER/Outpatier	IL SLIDOA		ng Home 5 Resid	dence 6 Other (Speci	fy)
ū	ding P h. After t funera	on:	27. Mann of Death 1 ✓ atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Work?	28d. Describe	now injury occurred	
sio	Attanding r death. actor: After by the funer	cati	2 Accident investigation			M :	1 ☐ Yes 2 ☐ No			
Division	or Att	Certification;	3 Suicide 6 Could not determined		iome, farm, str fy)	eet, factory, offi	ice	28f. Location (3 City or Tov	Street and Number or Rur vn, State)	al Route Number,
	le Hospital or Attandi 124 hours after death 1e Funeral Diractor: A iletely filled in by the f							1		
	Hospital 24 hours a Funeral I tely filled	ical	(Check only 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination	owledge, deat ation and/or in	h occurred at the vestigation, in m	e time, date and pl ny opinion, death o	ace, and due to the occurred at the time,	cause(s) and manner as : date and place, and due t	stated. o the cause(s)
	幸福 幸 诗	Medical	29b. Signature and title of certifier	and manner stated.			ense number		29d. Date signed (Month,	
	To To Con	-	250. Signature and little of Certifier	1 X X = N	-O-	Ì		1	- '	* '
•	140	Л	1 yeracel	J. 12- WEONIA	con		フレーノング	- MU	6-7-0	25
	72	1	,	completed se of death (Itel		,				
	-01		Michael S. Szkot					ard, Cali	tornia, MD 2	20619
	Sta Registr		31. Date filed (Month, Day Year)	7 2005 Registrar's Sign	· K	fresh				

Dwavne T. Jarboe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-3615 State of Maryland / Department of Health and Mental Hygiene AKG For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:00 PM Dwayne Thomas `Jarboe 2005 May 25. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** St. Joseph Medical Center
5. Social Security Number 6. Sex Towson Baltimore County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 42 Yrs. Birthplace (State or Foreign Country) Funeral Months 1**X** M 2 □ F Director 212-72-4139 Nov 1962 Washington DC Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits Baltimore show in than "natural", or items 23a or 28a-f show The Medical Examinations to cottling at Maryland Baltimore 1 Yes 2 No Completed by Funeral Director death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 United States 10815 Powers Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or Itel 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Electrician 12th traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Phyllis Zuck Harvey T. Jarboe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 12261 Catalina Dr. Lusby MD 20657 Harvey T. Jarboefather item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) May 28 2005
Metropolitan Funeral Service Alexandria Virginia 20a. Method of Disposition Pages 1 to 1 ☐ Burial 2 ACremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Rausch Funeral Home Service Licensee 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician omolica disease or condition resulting in death) /Medical Due to (or **Examiner** Sequentially list conditions. Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 No Yes 2□No

Records, Division of Vital

The law requires that the death certificate be executed Completed page 2 Physician: Be 은 Certification; death. after death | Director: | d in by the 1 Medical

To the Hospital or Attending within 24 hours aft

To the Funeral Di

completely tilled in

25. Was case referred to medical examiner? 1X Yes 2 □ No 27. Manner of Death 1 Natural 2 Accident 3 🗌 Suicide

4 T Homicide

29a. Certifier

5 Pending investigation 6 ☐ Could not be determined

Hospital: 1 XInpatient Date of Injury Month, Day

and manner stated.

2 ER/Outpatient 3 DOA

28b. Time of ChKnowa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. li

OCME

Other:

4 Nursing Home 5 Residence 6 Other (Specify) 28d. escribe how injure

adder 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

23a) (Type, Print)

MAY 27, 2005

26. Place of Death (Check only one)

o completed cause of deam (N

111 Penn Street Baltimore, Maryland 21201

State Registrar

filed (Month, Day, Year) JUN - 1 2005

ame and address of person w

29b. Signature and title of certifier

ysici: Nedic		Decedent's Name (First, Middle, Las FIFASE JOHNSON	r)					2.	Month 05–31–		Year	3. Time of Death
amin		4a. Facility Name (If not institution, give HOLY CROSS HOSPITAL	street and number)			SILVER					unty of Death	-
eral ctor		5. Social Security Number 578-26-772 Usual Residence of Decedent	7. Age ☐ M 2 X F 9		Yrs.	If Under 1 Yea Months Day			Date of Birt	n Y3 ^{Year)}	9. Birth Con SWII	nplace (State or Foreig untry) H CAROLINA
the bed	tor	10a. State MD 10b. County PRINCE GEOR	Œ'S	10c. City HYAI'I	Town or Loc SVILLE	ation						10d. Inside City Limi
st be not	I Director	10e. Street and Number 2017 VAN BUREN SIRE	Er			10f. Zip Code 20782				10g. Citizen U.S.A.	of What Co	untry?
the Medical Executive must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 N If Yes, Give Year or Dates:		lf.	Vas Decedent of Yes, specify Cu	ban, Mexican, i	n? (Specif Puerto Ric	y Yes or No- an, etc.)	BI	Race - Amer Black, White ACK ecify:	
the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		+)	(Give)	ent's Usual Occ kind of work don OO NOT use retii	e during most o	of working			of Business/l	
event,	To Be C	17. Father's Name (First, Middle, Last) FFASIFR MOSS					18. Mother's		irst, Middle,	Maiden Sui	тате)	
other treumatic		19a. Informant's Name/Relationship (7			19b. Mailin 2017 V	g Address (Stre N BUREN S	et and Number STREET HY	or Rural R ATTSVI	LLE, M	5 20782°	own, State, Z	ip Code)
		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		CE	Metery, crem LAND NAI	_	6-5	Date 9–2005	S	UITLAN	ion - City or 1	Town, State
any injury or once.		21. Signature of Faneral Service Licent	ne all		²² 301	Name and Add	ress of Facility	T MAX.	RHINE	S CO.	017	
cian liner transit the private stransit the private	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. PNEMONI Due to (or as b. LING CA Due to (or as c. Due to (or as d.	a consequ VER a consequ	ence of):							Onset and Death
tached for use as	Physician/Me	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnar Other (specify)	псу			23d	Date of deli	very Day Year
e 2 should be de	Completed by Pr	Part II. Other significant conditions of CHRONIC OBSTRUCTIVE	o o		•	derlying cause (given in Part I.		1 □ Y 24a. Was autop	res 2□N	4b. Were aul	the cause of death? bbably 4 Unknow topsy findings availation of cause of the cau
pa	Be	25. Was case referred to medical examiner?	Hospital:	v					Check only o			
rector, pag	- To	1 Yes 2 ZXvo 27. Magner of Death 1 Xatural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ry	ER/Outpatien 28b. Time of Injury	28c. In	other: 4 □ Nurs ork? □ Yes 2 □ No	280	5 ∐ Resid			eny)
funeral director,	atlon		28e. Place of Inju	ury - At ho c. (Specify	me, farm, stro	eet, factory, offic	е	28f	Location (S City or Tox		lumber or Ru	ral Route Number,
in by the funeral director,	Certification	3 Suicide 6 Could not be 4 Homicide determined	building, et									
in by the funeral director,	edical Certification;	4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc. ysician: To the best of the basis of and manner sta	examinat		restigation, in my	y opinion, death		at the time,	date and pla	ace, and due	to the cause(s)
funeral director,	Medical Certification	4 Homicide determined 29a. Certifier (Check only 2 Medical Exam	building, et ysician: To the best niner: On the basis of	examinat		restigation, in my			at the time,	date and pla 29d. Date si		to the cause(s)

amend ite, #21, perFH, DVR, G844, 6720/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat **Physician** Month Day 27 2005 12:45 p^м May Zane Kennard King, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Yrs Director 79 218-16-0440 Jan. 6, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location itam 27 is markad othar than "natural", or itama 23a or 28a-1 show othar traumatic avant, the Medical Evanther must be routiled at 10d. Inside City Limits Completed by Funeral Director 1√2Yes 2□No MD Chesapeake Beach Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7925 Old Bayside Road 20732 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 21⁄2 No 3 ☐ Widowed 4 ☐ Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) mechanic 12 Naval Research Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental H John Richard Myrtle Elizabeth 2 Kina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 7925 Old Bayside Rd., Chesapeake Beach, MD Mary L. King, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ö permit. Page Department of Important: If any injury or once. Mt. Harmony Cemetery 05-31-2005 Owings, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William R. Gross perDVR 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician CUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner as the burial-transit The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I the 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHIRENIC OBSTRUCTIVE PULMONARY D 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 DISE 1 Yes 2EMO 3 Probably 4 □Unknown Completed POCY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 🗆 Hospital or Attanding Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATMens. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSP RD PRINCE FREDERICK ANWAR MUNSAI. 110 MD

State

Registrar

31. Date filed (Month, Day, Year)

32. Registra Signature

JUN - 3 2005▶

		1 - For State Registrar	State of Maryla	and / Depa	artment rtificate	of H	ealth a	and M	lental Hy	giene (05	20278
		Registrar 1. Decedent's Name (First, Middle, Last)		Ce.	lincale	OIL	Jeani		2. Date of De	Reg. No.		3. Time of Death
Physic		Lawrence F. Ken	nody Ir						June	Day 1	2005	7:43 P M
/Med		4a. Facility Name (If not institution, give si			4h Cily T	own or	Location of	of Death	ounc		ty of Death	
Exam	iner	Somerford Place	noot and nambor,				olis	or Death			Arun	
Funera		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under	1 Year	if Under	24 Hrs.	8. Date of Birt			
Director		019-16-7545	M 2□F 81	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da Sept. 1	3,1923	Mas	place (State or Foreign ntry) SS •
9		Usual Residence of Decedent										
ırylar show	_	10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
8a-f	cto	MD Anne Arund	el	Anna	polis							
vith th	Dire	10e. Street and Number			10f. Zip (2.4			10g. Citizen o	f What Cou	ntry?
s 23s	Funeral Director	2717 Riva Road				2140		. 0 /0	7 11	USA		
er de Item	n n		 Was Decedent Ever in Armed Forces? 1 X Yes 2 No 	1 U.S. 13.	Was Decede If Yes, speci	ent of His fy Cubai	spanic Ori n, Mexican	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	- 14. H	ace - Ameri lack, White,	
rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW	тт	1 ☐ Yes 2	No I	Specify:			Spec	eify: Whit	te
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othe vent,	Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	e (First, Middle,	Maiden Sum	ame)	
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_ CDEE		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	al Route Numbe	r, City or Tow	n, State, Zip	o Code)
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Dallimore Dermit. Pages 1: Department of He mportent: If iten any injury or oth once.	1	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	20t	o. Place of Dispo cemetery, crei	sition (Name matory or other	e of her place	9)		Date	20c. Location	n - City or To	own, State
Pag Pag nent ent: I		`4 ☐ Donation 5 ☐ Other (Specify)	M	aryland	Vet.	Ceme	etery	06/	06/2005	Crow	nsvill	Le, MD.
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/Medical Examiner	_	resulting in death)	Due to (or as a cons	sequence of):	1							
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~(') \W	9	30. Name and address of person who cor Aditya Chopra, M.D		dgely Av		ui to	231	۸+	nnapolis	z MD	21401	
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Regis		JUN 0 3 2005	2. Registrar's Sig	y April	w							

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jane Elizabeth KELLER June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F Hours Yrs. Director 212-14-7057 86 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "netural", or items 23a or 28a-f show other treumatic event, the Medical Exerther must be notified at 1 Tyes 2X No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 17406 Lexington Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "netural", or iter Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Completed by Specify: 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 is marked oth eny Injury or other treumatic event 2008. Shelton Hetzer Georgia Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamala Triesler - daughter 236 North Carolina Ave., Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 6/8/05 * 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or confiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner ARTERY DISCAUSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequ Examiner burial-transit signed by the attending physician and be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco-use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown Completed ORGAN FAILURE WITH URECUA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2 1 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 1 patient 2 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification; 28d. Describe how injury occurred After Vatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State JUN 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** 12, June 6:00 a^M Geraldine Marie Lowe /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner 1804 Baldwin Mill Road Forest Hill Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 29,1936

9. Birthplace (Stete or Foreign Country)
Pennsylvania Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛣 F 68 213-36-8841 Director Usuel Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits I and 2 should be filed within 72 hours after death with the Marylan feath and Mental Hygiene.

Sm 27 is marked other then "natural", or Itams 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at MD Harford Forest Hill 1 Yes XXNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1804 Baldwin Mill Road 21050 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2XXIII Specify: Specify: White Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Grocery Store 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernita Marie Bowman Edgar Charles Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1804 Baldwin Mill Road, Forest Hill MD Richard B. Lowe f Health other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stewartstown
Cemetery June 16, 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If Iter
eny injury or oth Stewartstown, 3 XRemoval from State 1 Burial 2 ☐ Cremation ¹ 4 □ Donation 5 Other (Specify) Pennsylvania 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc 19 S. Main St., Stewartstown, PA 17363 21. Signature of Funeral & fair. Enjoy the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) ONCON **Physician** anteriom o /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate ha 1 Yes 2 No 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 2 ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending after death.

Director: Af
in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L t 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 045390 June 13, 2005 Name and address of person who completed cause of death (Item 23a) Type. Print) NIN (N.D.) COZ Sowth Atwood Road #200, Bel Air, MD21014 3 MYO MIN(M.O. 32, Registrar's Signature 31. Date filed (Month, Day, 7 2005 State Registrar

RPD

Delores Thompson Lancaster 05 -03726 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of State Amend Item 1&Unpend Item 23a, pt. 11, 27, 28, 18, 18, 18, 18, 18, 18, 18, 18, 18, 1	f Health and Mental Hygiene () 5 8a-f per me 6844 of Death6-21-05 tas _{Reg. No.}	20281
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-			Doctor's Communit	v Hospit	a1	La	nham				Prince	George's	
D T	Funeral		5. Social Security Number 6. Sex	7. Ag	ge (In yrs. last birth		nder 1 Year	If Under 2	24 Hrs. 8	Date of Birth	9.	Birthplace (State or Ford	reign
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	be filed within 72 hours after death with the Maryla hal Hygiene. d other than "natural", or Items 23a or 28e-f shov event, Tre Medical Evartiret marke portified at	Funerai Director	11, Marital Status	2. Was Decedent Armed Forces?	Ever in U.S.	13. Was D If Yes,	specify Cuba	lispanic Orig	gin? (Speci	fy Yes or No- can, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.	
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Physician Riedical Examiner Page Physician Riedical Examiner Physician Condition				23a. Part1. Enter the disease, or com- shock or heart failure. List only	plications that caused to	he death. Do not er	ter the mode of dying,	such as cardiac o	r respiratory a	rest,	A	Approximate
Due to (or as a consequence of): Sequentially list conditions, cause. Finish Underlying cause. Einst Underlying cause given in Part I.				Immediate Cause (Final disease or condition			ispurie	5			Ö	Onset and Death
State St	1			resulting in death)	Due to (or as a	consequence of):	7					
State St			er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					_	
The continue of the past 12 months? 23d. Date of delivery 23d. Date of d		cuted nd ransit	amin	Cause, Enter Underlying Cause (Disease or injury that initiated events	C						*	
FFEMALE 23d. Date of delivery 23d. Date of deliv	50,	00 execian a	I Ex	resulting in death) Last	Due to (or as a	consequence of):						
FFEMALE 23d. Date of delivery 23d. Date of deliv	387		dlce		d							1550 25
9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1		ath certif attending for use a		23b. Was decedent pregnant	1 Live birth 2	Fetal death 3						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001 JUNE 8, 2005 JUNE 8, 2005 JUNE 8, 2005 32. Registrar's Signature		the de	yslo			me or death 5	∪ther (specify)					,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001 JUNE 8, 2005 JUNE 8, 2005 JUNE 8, 2005 32. Registrar's Signature	sior	endir. eath. or: Af	atlo	2 Accident investigation	6/7/05	0:00		s 2 No				
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State Registrar 31. Date filed (Month, Day, Year) JUN 1 6 2005 32. Registrar's Signature		To t To t	M	> Talinill	100 AC		OCME	number				y, Year)
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	e . 33		1 - Registrar6-3-05Amend#29d.PerPhys.PCCr Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No U U	3. Time of Death
п	Physici		Odaris Hattie Lea	Month	Day Year	
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	May	27, 2005 4c. County of Deal	2:14 A. [™]
1			Prince George's Hospital Center Cheverly		Prince Ge	orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi (Month, Di 3/17/	rth 9 Birt	holace (State or Foreign
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	iand ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many	ţ	D.C. Washington			1 X Yes 2 ☐ No
	th the	lrec	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	23a 23a	by Funeral Director	570 23rd Place, N.E. 20002		U.S.A.	
	er de (nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (St. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)	o- 14. Race - Ame Black, Whit	ncan Indian, e. etc.
36	I', or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:			erican
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-1 show he Medical Exama er must be redified at	ted	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind of Business/	
218	thin 7 e. en "n Medi	Completed	(Specify only highest grade completed) (Give kind of work done during most of work for eduring most of work for eduring most of work for eduring most of work for educing	king		ŕ
	ed wi ygien ner th	Con	9th Homemaker		Own Home	
and	be fil d off	Be	Living a m		, Maiden Sumame)	
Ĕ	hould d Mei mark matic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru.	ia Hint		Tin Codo)
Maryland	nd 2 s lth an 27 Is		Russell I. Lea/Son 2401 Lewis Ave., Suitl			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Wedical Exand act must be notified at ODGs.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	
Ë	Page ient o nt: If ry or		1 XBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Harmony Mem. Park 6/2/	05	Landover,	Md.
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington &	Sons Co		
ω_	89 = 88		any W. Shau 4925 Burroughs Ave	.,N.E.,	Washington,	o.c. 20019
8760,	law requires that the death certificate be executed Example as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on each line. URINALY THACK INFECTION Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	4		Interval Batween Onset and Death
P.O. Box 6	the death certific by the attending pl ached for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)		23d. Date of del Month	very Day Year
Records, P	w requires that the de been signed by the a should be detached t	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEUMLITIS RIGHT LES		tobacco use contribute to Yes 2 □ No 3 □ Pr	the cause of death?
eco	ie law requ has been ge 2 should	plet	DIABETER MELLITUS	24a. Was	an 24b. Were au	topsy findings available
H.	The ate h page	Com	CORONARY ARTERY DISEASE	perfo	ormed? death?	2 No
/ita	ician: Th certiticate rector, pag	Be	25. Was case referred to medical examiner?	th (Check only	one)	
of Vital	Physician: this certitics ral director,	2			dence 6 Other (Spec	eity)
O	ding h. Atter fune	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 4 Nork? 1 Yes 2 No	28d. Describe	now injury occurred	
Division	Attending in death. ector: Atterby the funer	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Ru	ral Route Number,
Ö	ospital or Attendi hours atter death. Ineral Director: A y tilled in by the fu	Certification;	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)	
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely tilled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To t	Z	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	Day, Year)
,			D0043662		3/-1709	5/27/05
R			30 Name and address of person who completed cause of death (Item 23a) (Type, Print) WINIAM BUYCE PG HUSP 3001 HosPiTAL DR	CH	EVERLY, MD	20185
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 3 2005 3 Registrar's Signature			

				For State Registrar	State	of Mary		artment of F		Mentai Hy	giene	Ûō	20284
				1. Decedent's Name (First, Midd	le, Last)					2. Date of D			3. Time of Death
_		Physici		THOMAS	L.	L	INDSEY			Month MAY 3	Day 1, 2005	Year	2:10 P M
		/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of De			ty of Death	
		LXaiiii	ei	JOSEPH RICHEY		·		BALTIMO)BE				
3		Francis		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)			S. B. Date of B (Month, D	rth	9. Birth	place (State or Foreign intry)
P		Funeral Director		264-03-3655	1 M 2 □ F	91	Yrs.	Months Days	Hours Mi	n. (Month, D			RIDA
19				Usual Residence of Decedent	1	J					4	1 1 10	IIIDA_
Z		yland		10a. State 10b. County	1	100	c. City, Town or Lo	ocation					10d. Inside City Limits
6		Mar Feb	ţō	DC		Į.	WASHINGTO	NC					1 X Yes 2 No
0		288	rec	10e. Street and Number			MADITINGI	10f. Zip Code			10g. Citizen of	What Cou	ntry?
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1/2	•	after death with the Maryland or Itams 23a or 28a-f ehow ruiner : wat be ruciffed at	Funeral Director	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Was Decedent of H		(Specify Yes or N		ace - Ameri	
13/	0	r Ita	Fur	1 ☐ Never Married 2 X Ma	ried Armed F	2 No	i i			erto Hican, etc.)		ack, White,	
	8	urs a lal', o	by	3 Widowed 4 Divorce	If Yes, G Year or	ive Dates:		1 ☐ Yes 2 🔀 No	Specify:		Spec	ify: BLA	CK
	5-0036	2 ho	ted	15. Decede	nt's Education	4)	16a. Dece	dent's Usual Occup	pation	vorking.	16b. Kind of	Business/Ir	ndustry
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S	pu	al Hy al Hy I oth	Be (17. Father's Name (First, Middle						ame (First, Middle		me)	
1	/lai	uld b Ment Ment arkac	To	SHERMAN LI	NDSEY				CLARA	RASHA	RD		
1	Maryland	12 sho h and 7 is mu trauma		19a. Informant's Name/Relation MABEL H. LIND		! !		ng Address (Street DIVISION					
Z ×		s 1 and f Healt item 2 othar		20a. Method of Disposition		20	Ob. Place of Dispo			Date	20c. Location		
om	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Madical Evantmetrivial by multiplical any injury or other traumatic event, the Madical Evantmetrivial by multiplical and once.		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Specify)	n State I	FT. LINC	OLN CEMET	ERY 6-	4 - 05	BRENTW		
K	Balt	permit Depart Import any in		21. Signature of Funeral Service Theo dose	Licensee Tu	ie mes		2. Name and Addre 24 - 8TH					ERAL HOME
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			ner	Sequentially list conditions,	b. Due to	o (or as a cor	ns-quence of						
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	687	ificate g phys as the											
	P.O. Box 68760,	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 🗍 gnant at time	Fetal death 3	Ectopic pregnanc Other (specify)	<i>y</i>			ate <i>o</i> f deliv fonth	rery Day Year
		uires that the de signed by the a ld be detached f	/ Ph	Part II. Other significant condit	ions contributing to	death but no	nt resulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
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	of	ding Phys h. After this funeral di	 -	27. Manner of Death	- Annual Control	e of Injury onth, Day Yea					how injury occu		,
	0	th. : Afte	iệ.	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Mo	ntn, Day rea	ar) Injury		rk? Yes 2 □ No				
	Division of Vital Records,	r Attender death	Certification:	3 ☐ Suicide 6 ☐ Could	mined 289. Pla	ce of Injury - ding, etc. (S	At home, farm, st	reet, factory, office			(Street and Num	iber or Rur	al Route Number,
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		To the Hospital or Attending Physician: within 24 hours after death. Jo the Funeral Director: After this certific completely filled in by the funeral director.	Medical		I Examiner: On the								
		To ti	Σ	29b. Signature and title of certifi				29c. Licens	1	2	29d. Date sign	ed (Month,	Day, Year)
		15		. Xare	V & In	4		00	00 70	/	11124	31,	2005
		De C			VOX. W	5	9 W-	.4 / ^	n. 13	2140 U	מוג מת	10-1	303
		Sta Regist		31. Date filed (Month, Day, Yea. JUN 0 3 2005	Blocus 32.	Registrar's S	Signature						

05-03894 Jam

es	Lucas		Please Type or Print in			•	•				
			State of Maryla 1 - State Unpend Item 23a, pt.II,27	per me	G844 6-22-05 dificate of Death						
н	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year				
	/Medic	al	JAMES E.	LUCAS	4b. City, Town, or Location	June	05, 2005 03:58 A ^M				
	Examin	er	4a. Facility Name (If not institution, give street and number)				4c. County of Death				
	Funeral		St. Mary's Hospital 5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday)		r 24 Hrs. 8. Date of Birth	St. Mary's 9. Birthplace (State or Foreign Country)				
	Director	Ineral Months Days Hours Min, (Month, D					13 1937 North Carolina				
}	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 is marked othar than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclined at			City, Town or Lo	ocation	•	10d. Inside City Limits				
		tor	MD Charles M	lechanic	ville		1 ∏ Yes 2 ☐ No				
)irec	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?				
		al	37099 Asher Road 20659 U.S.A.								
		nne	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.				
036		by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		1 ☐ Yes 21☑ No Specify	z:	Specify: Black				
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)	6b. Kind of Business/Industry							
212	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12th	ntence	Government						
פָּ	e filed at Hygie othar vant,	BeC	17. Father's Name (First, Middle, Last)		18. Moth	ner's Name (First, Middle, M	aiden Sumame)				
Maryland	2 should be and Mental is marked c	To	Grover Lucas			Elnora Kell	1y				
lar)	and the is me		19a. Informant's Name/Relationship (Type, Print)		•		City or Town, State, Zip Code)				
	1 and 2 Health am 27 other tra		Ester Lucas/Wife		Asher Rd. Me						
Ore	ges 1 it of H if itar or oth		20a. Method of Disposition 20b 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crei	osition (Name of matory or other place)		0c. Location - City or Town, State				
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other to once.		' 4 □ Donation 5 □ Other (Specify) H 21. Signature of Funeral Service I censee				andover, Maryland				
Ba	permit, Pages 'Department of H Important: If ite any injury or ot		21. Syllame of ruleral Service Itemsee				ins Funeral Home er, Maryland 20785				
	ă.		23a. Part1. Enter the disease, or comprisestions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between								
	Physician	0.0	Immediate Cause (Final disease or condition Colonic Infarction								
	/Medical Examiner		resulting in death) Due to (or as a consequence of):								
	CXAIIIIIIei	_	Sequentially list conditions, Due to (or as a consequence of):								
	bed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisese or Figury								
	icate be executed physician and s the burial-transit	Examiner	that initiated events c								
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89	leath certificate b rattending physic I for use as the b										
Вох	th cer		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fe	23d. Date of delivery							
	he deal the att	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Month Day Year							
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000						24a. Was an					
Re	The law					——— autopsy perform 1.∡ Yes 2	ed? death?				
of Vital		Be C	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check only one					
ξV	N S	70 E	1 Yes 2 No Hospital: 1 XInpatient 2	☐ ER/Outpatier	nt 3 DOA Other: 4 N f 28c. Injury at Work?	lursing Home 5 Resider	nce 6 Other (Specify)				
	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year)	w înjury occurred							
<u>S</u>	Attending ir death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	home form at	M 1 Yes 2		and Number or Rural Route Number,				
Division	after of Dirac	Certification;	determined 200. I lace of Injury At	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town,	tate)				
	To the Hospital or Attend within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical Co									
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number OCME	29	d. Date signed (Month, Day, Year)				
(lue)						J	June 08, 2005				
_(K		30. Name and address of person who completed cause of death (III)		TT1 Penn Stre	eet Baltimor	e, Maryland 21201				
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 0 2005	nature	E .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MARTHA MARY LOWERY unce 1 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Kegural reninsula Jalisbun WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Hours Months Days 1□M 2√F Yrs. Director 189-01-6751 11-09-1913 PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "naturel", or Items 23e or 28e-f show the Medical Examinary rust be notified at 1 Yes 2 No Completed by Funeral Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1414 ARD-BRAC PLACE 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give² Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 12 SWITCHBOARD OPERATOR HOSPITAL other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS MORGAN HANNAH STADT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i SANDRA WATSON - DAUGHTER 4142 HARVEST LANE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₹ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) WICOMICO MEM. PARK 06-04-2005 SALISBURY, MARYLAND 21. Signature of Edneral Solvice Lightsee 22. Name and Address of Facility $BOUNDS\ FUNERAL\ HOME$, INC.705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part1. Ent, the lise shock, of he it fail in 6. of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCAROICL INTARCTION / DAY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 No Yes of Vital Physicien: 25. Was case referred to medical examiner?
Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 10 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation after death. 1 Tes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a To the Funerel I filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

RONDED

31. Date filed (Month, Day, Year) 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

P.

7-12-681 #5

DHMH 17 Rev 1/2001

29c. License number

TRADITZ MD 560 Reversale DR Salesles

00036576

29d. Date signed (Month, Day, Year)

NO

		•	For State Registrar	State of Ma	•		artment of H		and Mental H	ygiene Reg. Ná	2005	202	287
	Physici	an	1. Decedent's Name (First, Middle, L	•					2. Date of I Month	Death Da	y Year	3. Time o	
	/Medic	al.	Elizabeth J. M				4h Oh Tara		June	1	2005 County of Deat	8:55	Ам
	Examin	er	4a. Facility Name (If not institution, gi 5555 Friendship				4b. City, Town, or Chevy C		t Death		-		
	Funeral			Sex 7. Ag	e (In yrs. last bir	thday)	If Under 1 Year	If Under :	24 Hrs. 8. Date of I	Birth	ontgomen 9. Birti	hplace (State ountry)	or Foreign
	Director		089-09-7558	1□M 2 F	93	Yrs.	Months Days	Hours	Min. (Month, Oct.	Day, Year) 0 19	1	ontry)	
	72 hours after death with the Maryland inetural; or items 23a or 28a-f show dical Examiner mat be conflict at	Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or i c	ncation					10d. Inside C	lity I imits
				0.4617	,								2 🗆 No
			MD Montgom	ery	Chevy	Una	10f. Zip Code			10g. Cit	tizen of What Co	untry?	
		al Di	5555 Friendship Blvd #405 USA										
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H	ispanic Orig	gin? (Specify Yes or I	No-	14. Race - Ame Black, White		
36	s after	by Fu	1 Never Married 2 Married	1 □ Yes 2 💥 If Yes, Give	No		1 ☐ Yes 2 🎇 No	Specify:			C:6	Thite	
2-0036	hours tural												
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural", or any injury or gaher traumetic event, the Medical Exercions.	၉	William George		405	B 4 - 10			ie Bateman			7:- C- d-1	
Mai		P	19a. Informant's Name/Relationship		60		-		er or Rural Route Num ethesda, M			up Code)	
			Elizabeth Record 20a. Method of Disposition	/ Daugnte			osition (Name of matory or other place	-	une 3, 200	-	ocation - City or	Town, State	
m 0			1 ☐ Burial 2X Cremation 3 14 ☐ Donation 5 ☐ Other (Spec		Mt. Co			(B)	une 3, 200		andria,	Virgin	of o
Baltimore,			21. Signature of Funeral Service Lic					ss of Facilit	yJoseph Ga	wler'	s Sons	لىلىق لى ك V	Ld.St.
Δ			W. Chiffy	Muray	/	5	130 Wisco	onsin	Ave. NW W	ashir	ngton DC	20016	
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	P nysecian and /Medical Examiner parish sician and prival-transit		Immediate Cause (Final disease or condition Inanition								Death		
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σ,									in Part I. 23e. Did tobacc		co use contribute to the cause of death?		
rds		ed b							1(1 Yes 2 No 3 Probably 4 Unknown			Unknown
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of		6	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing						-	Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred			
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Ö	al or A s after al Direct	Cert	4 ☐ Homicide building, etc. (Specify) City or Town, State)										
	To the Hospital or within 24 hours after To the Funerel Dirticompletely filled in I	edical C									s)		
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)	1>		Me /	- Xus			D39	456		Jt	une 2, 2	.005	
	15		30. Name and address of person wh										
	• 4	-	Lila McConnell, 31. Date filed (Month, Day, Year)					y Cha	se, MD 208	15			
:::	Sta Regista			1005 Maria	rar's Signature	400	ule						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			FOI	epartment of Health and I Certificate of Death	Mental Hygie Reg.	0000	20000			
	Physicia /Medic		Decedent's Name (First, Middle, Last) Laura Mildred	Mills	2. Date of Death Month June 1	Day 2005	3. Time of Death) U			
	Examin		4a. Facility Name (If not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll County				
	Funeral Director	tor	5. Social Security Number 6. Sex 1 Mr 2 Mr 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sep. 18	9. Birtho 1914 Mary	Birthplace (State or Foreign Country) Maryland			
21215-0036	Maryland f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll County Westminster 1X1 Yes 2 □ No							
	with the a or 28a ibe notifi	Direc	10e. Street and Number 205 St. Mark Way	10f. Zip Code 21158		Citizen of What Cour	•			
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinating must be notified at other traumatic event,	by Funeral Director	11. Marital Status 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 🏋 No Specify:		14. Race - Americ Black, White, Specify: Whi	ean Indian, etc.			
		Completed	Flomentary/Secondary (0.12) College (1.4ex 5.)	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired) sales clerk		pharmacy	Kind of Business/Industry Dharmacy			
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Jacob Perrott	1	ne (First, Middle, Mai Bartles	iden Sumame)				
_				Mailing Address (Street and Number or Ru OO Compton Way Me		ity or Town, State, Zip Florida 32				
altimore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		1 ▼ Burial 2 □ Cremation 3 □ Removal from State cemetery		- 16	c. Location - City or To laneytown,				
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sk 136 East Baltimore	iles Funer	al Home Taneytown,	Md. 21787			
	Iticate be executed Medical Examiner Is the buriat-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Onset and Death							
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Division of	a Hospital or Attending Physician: The 24 hours after death. b Funeral Director: After this certificate has telly filled in by the funeral director, page	ıtlon: To	27. Magner of Death 28a. Date of Injury 28b. Ti			esidence 6 □Other (<i>Specify</i>) se how initury occurred				
Divis		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	(Street and Number or Rural Route Number, wn, State)				
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)			
}	To the I within 2 To the I complet	Me	29b. Signature and title of certifier Trace Z. Ryberg D	29c. License number	29d.	Date signed (Month,	Pay, Year)			
	3		30. Name and address of person who completed cause of death (from 23a) (1)	Type, Print) 5 HANOVER PIKE	MANCH	ester m	D 21192			
;	Sta Registr		31. Date filed (Month, Pay, Year) 2005 Registrar's Signature	bell	V 3122 (1)					

•	1	For State Registrar	State	of Ma	aryland	-	rtment				ental Hy	- /1	nns	20200
		1. Decedent's Name (First, Middle	. Last)			Cei	incate	- OI L	Jeaur		2. Date of D	Reg. No.	000	3. Time of Death
Physician		Thomas Milazz									May 30	Day	Year	12:20 A.M
/Medical Examiner	-	4a. Facility Name (If not institution,		umber)			4b. City,	Town, or	Location of		ray or	-	nty of Death	
		Calvert Memoria	l Hospita	al			Prin	ce F	rede	rick		Calv	ert	
Funeral		,	6. Sex			st birthday)	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year)	9. Birth	place (State or Foreign intry)
Director	- h-	098-18-9034 Usual Residence of Decedent	1 M 2 □ F	79)	Yrs.				į	Jan. 9	1926		York
land ow	-	10a. State 10b. County			10c. City,	Town or Lo	cation							10d. Inside City Limits
n the Maryland r 28a-f show notified at	2	Maryland Calver	+		Port	Repu	blic							1 ☐ Yes X☐ No
with the Mar n or 28a-f si be notified	2	10e. Street and Number					10f. Zip	Code	-			10g. Citizen	of What Cou	untry?
72 hours after death with the Maryland 72 hours after death with the Maryland naturel; or Items 23s or 28s-f show deat Examiner must be notified at the day Funeral Director	2	3035 Mandela Co	urt				206	76				United	State	es
riter death viritems 23s		11. Marital Status	12. Was De Amed F	orces?		5. 13. V	Vas Deced Yes, spec	ent of His	spanic Ori n, Mexicar	igin? (Spe n, Puerto f	cify Yes or N Rican, etc.)	o- 14. F	lace - Amer Black, White	
urs afte		1 ☐ Never Married	If Yes G	live	™ TI	- 1	☐ Yes 2	X) No	Specify:			Spe	city: Tab	ite
hour turel		15. Decedent		Dates.	AAAA T.1	16a. Deced	ent's Usua	l Occupa	ition			16b. Kind of		
	-	(Specify only highes Elementary/Secondary (0-12)		-		(Give	kind of wor OO NOT us	k done d	luring mos	t of workir	ng			,
other then "naturent, the Modest	5	11	College	(1-401 5	1	Carpe	nter					Build	ing	
2 = + + C	9	17. Father's Name (First, Middle, I	_ast)					- 1				a, Maiden Sum	name)	
2 should be if and Mental H is marked of raumatic evel		James Milazzo						- '	Rose					
12 sh h and 7 Is n traun	1	19a. Informant's Name/Relationsh										oer, City or Tov		
es 1 and 2 of Health (item 27 in other tra		Jean Milazzo (W 20a. Method of Disposition	ite)		20b. Pla	3035 ace of Dispos	Mande sition (Nam	la C	curt	, Por	t Repu	iblic, 20c. Locatio	Maryl: on - City or T	and 20676 own, State
Pages nent of nnt: If it		N☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State		_{metery, cren} Jetera	natory or of	ner place	9)					Maryland
	-	21. Signature of Funeral Service I			110							neral		
permit. Departr Importe any inji) (2/C)	MOC		ı									e, MD 20676
7077.3	1	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused each lin	the death.	Do not ente	or the mode	of dying	g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	n. Ac	. 4		min	car.	1.0	1	1 000	ten	3.20		Onset and Death
/Medical Examiner	1	resulting in death)	Due to	or as	a conseque	ence 4			172.4	C	22	30.25		
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executed n and ial-transit		Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	62			G1111G G1	· · · ·	29:21	×					
be executed sician and burial-transit	LAG	that initiated events resulting in death) Last	c. Du∍ to	or as	a conseque	ence of):		-	7					
nte be nysicia ne bur	2		بلام_ه	13	Mil	lene	in		-					
iffica ph as the	3 -	IF FEMALE:			4									
attending p	8	23b. Was decedent pregnant in the past 12 months?		birth	2 Fetal	death 3	Ectopic pre						Date of deliv Month	very Day Year
at the death cert d by the attending etached for use a	3010	1 ☐ Yes 2 ⊡ No 9 ☐ Unknown	4∐Preg 9□Unk		time of dea	ath 5∟	Other (spe	ecify)			·			
that the that the detact detact		Part II. Other significant condition	ns contributing to	death bu	ut not resul	lting in the ur	iderlying ca	use give	n in Part I		23e. Did	tobaço use co	ontribute to	the cause of death?
uires ti							-				1 🗹	Yes 2□No	3 □ Pro	bably 4 🗆 Unknown
The law requir	1010										24a. Wa:	san 24	b. Were aut	opsy findings available
The lar	5											ormed?	prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of
	D	25. Was case referre medical							26. Place	of Death	(Check only			
hysicians certification of the	0	examiner? 1 ☐ Yes 2 🗹 No				R/Outpatien	_		4 140	ursing Hon	ne 5 mes	idence 6 🗆 0	Other (Speci	ify)
ding Pt h. After th funeral	5	27. Mann of Death 1 Natural 5 ☐ Pending		of Injur	Year)	28b. Time of Injury		3c. Injury Work			28d. Describe	how injury occ	curred	
Attendi death. ctor: A y the fu	2	2 Accident investig	ot be 290 Plac	e of Ini	Inv - At hon	ne, farm, str	M factors		/es 2□		28f Location	(Street and Nu	mher or Rur	al Route Number,
or Attending Fater death. Director: Atter Jin by the funera		4 ☐ Homicide determ			. (Specify)		set, factory	, OITICO				wn, State)	INDOF OF FIG	ar riodte rvaniser,
e i se se se se se se se se se se se se se)	29a. Certifier 1 Certifyin	g Physician: To th	ne best o	of my know	rledge, death	occurred a	at the tim	e, date an	nd place, a	and due to the	cause(s) and	manner as :	stated.
the Hosp hin 24 hou the Fune upletely fil	ממוני	(Check only 2 Medical I	Examiner: On the and ma	basis of nner sta		on and/or inv	estigation,	in my op	inion, dea	ith occurre	ed at the time	, date and plac	e, and due	to the cause(s)
To the within To the comp		29b. Signature and title of certifier							number	,	800	29d. Date sig		
., 0		yazda	M				D	171	68			6/30	105	`\
30		30. Name and address of person												
Chair		Kioumarce Yazda 31. Date filed (Month. Day Year)	ni, MD	2555 Registra	Solc ar's Signatu	mons :	Islan	d Rd	., Hı	ıntin	gtown,	Maryla	and 20	1639
State		31. Data filed (Month, Day Year)	Glass 32.	1	· de	rester								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Year JUNE 7, Рм FLORENCE MARY METZ 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST VINCENT de PAUL NURSING CENTER FROSTBURG ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 X F 214-06-6327 95 September 26, 1909 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Allegany Frostburg 1XYes 2 □ No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21532 48 Tarn Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. I ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2N No White Specify: Specify 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 0 10 18. Mother's Name (First, Middle, Maiden Sumame) Clementine Goodrich 17. Father's Name (First, Middle, Last) William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Schriver 19806 Big Lane, Midland, Maryland, 21542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 10, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg, Maryland Frostburg Memorial Park 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10415 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

The law requires that the death certificate be executed

the

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has

certificate

this

To the Hospital or Attending Physician:

death.

after

within 4 hours a To the Funerel C

Medica

State

Registrar

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a State

Director

Completed by Funeral

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, The Medical Exert front rouse be notified at once.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner attending physician and for use as the burial-transit detached Certification: To Be After thi Director:

IF FEMALE: 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

Natural

2 Accident

4 - Homicide

3 🗌 Suicide

29a. Certifier

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 20 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28l. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 Medical and manner stated 29b. Signature and title of ce

5 Pending investigation

6 ☐ Could not be

determined

29c. License number 00033280

Other:

29d. Date signed (Month, Day, Year)

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

2005

Hospital:

1 Inpatient

28a. Date ol Injury (Month, Day Year)

Johnson Heights Medical Building, Cumberland, Maryland Gupta m.D 54011

31. Date liled (Month, Day, Year) 9 JUN

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

			1- For Amend Items 23a,25,27,28a-f per ME, G844 Certificate of Manyland / Department of Jersen Jerse	Health and Ment Do 10/05dhb	al Hygiene	5 20291
			Decedent's Name (First, Middle, Last)	2. Dá	ite of Death	3. Time of Death
	Physici		William Mills			Year 120 A M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	4c. County o	f Death
1			University of Maryland Medical Ctr Bal	timore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8. Da Hours Min. (M	te of Birth conth, Day, Year) y 14, 1944	9. Birthplace (State or Foreign Country)
	Director		214-42-8504 156M 2 F 60 Yrs. Months Days	Mar	y 14, 1944	Maryland
	pu s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	sho	5		Madison		1 ☐ Yes 2 🕱 No
	28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	
	th with the Marylar 23s or 28s-f show	급	4667 White Marsh Road	21648		JSA
	eath	by Funerai		Hispanic Origin? (Specify Y		- American Indian.
	fter d	표	Armed Forces? If Yes, specify Cub	oan, Mexican, Puerto Rican,		White, etc.
936	urs a	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:	Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-f show ther then medical Examirer must be melified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done	pation during most of working	16b. Kind of Bus	iness/Industry
21	thin 7	pie	Elementary/Secondary (0-12) College (1-4or 5+)	ad)		
21	od wil	Con	10 truck dr		_ _	ortation
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23a or 28a-f shot anyt july or other traumatic avant, the Medical Examinational be notified at any injury or other traumatic avant, the Medical Examinational be notified at any force.	Be	17. Father's Name (First, Middle, Last)		, Middle, Maiden Sumame,)
<u>ya</u>	12 should be finance and Mental Fis marked of raumatic ava	မ	Harvey Mills	Marie Brit		
lar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street			
	l and lealth om 27 ther tr			larsh Road, Ma		21648
Or	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	1		ity or Town, State
ţ	t. Pa tmer tant:		`4 □Donation 5 □Other (Specify) Old Trinity Churc			Creek, MD
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Addr		as Funeral Ho	
	20244	\vdash	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy	st St., Cambr		Approximate
			shock, or heart failure. List only one cause on each line.	ng, such as caldiac of resp	natory arrest,	Interval Between Onset and Death
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			
	Examiner		Due to (or as a consequence of):			
		ь	Sequentially list conditions if any, leading to immediate D to (or as a consequence of):			
	on ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	FAIL	X All	/ _
ć	exec in an	Exa	resulting in death) Last D is to (or as a consequence of):	11	A A CONTRACAL	EXVINE
8760,	cate be executed physician and the burial-transit	dicai	d	TIFICAT	ON APPROVED BY MILICAL	
9		0	TO STATE OF THE ST	CEKINI		
Вох	The law requires that the death certific ite has been signed by the attending p tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnance	:v	23d. Date	
-	es that the death igned by the atte be detached for	sicia	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify) □		Mont	h Day Year
P.0	at the	Phy	9 🗆 Onknown			
	igned bed		Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	ven in Part I. 2	3e. Did tobacco use contrib	
ord	w requir been si should I	ted	MUF, Hypertension, Diabetes		1 Yes 2 No 3	Probably 4 Unknown
Records,	law las b	ηpie		24	autopsy pri	ere autopsy findings available or to completion of cause of
<u>=</u>		Completed by		1 (ath? IYes 2DYNo
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)	
of	Physical this call dir	6	Tampaient 2 Ervoupanent 3 BOX		Residence 6 Other	
n C	ng fter inel	on	1 Notice 1 S Pending (Month, Day Year) Injury Wo	ork?	escribe how injury occurred	
Sign	Attanding r death. ector: Afte by the fune	icat	3 Suicide 6 Could not be		ubject fell cation (Street and Number	or Pural Pouto Number
Division	or A after of Direction by	ertif	4 Homicide determined building, etc. (Specify)	Ci	ty or Fown, State) Camb	oridge, MD
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification;	Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the ti		chester Gene	
	24 h	dice	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my one)			
	ro the	Me	29b. Signature and title of certifier 29c. Licen	se number	29d. Date signed (Month, Day, Year)
	,- > F 0		MD AI	5228	51	1 05
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	•
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOWH GYCLUS 31. Date filed (MOTO Pay: 1Year) 2005 Registrar's Signature	reet Ba	Itimore w	W 21201
	Sta	ite	31. Date filed (Month Ray: 1Year) 2005 Registrar's Signature			
	Registr	ar	Joseph Jo Japan			

JET 05-03888 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Derrick Gerrard Moon State of Maryland / Department of Health and Mental Hygiene
For Unpend Item 23a,pt.II,27 per me G844 6-20-05 tas
Registrar
Registrar
Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Derrick Gerrard June 2005 1:08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 1**2** M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Yrs. 135-64-1828 NJ Director 39 3-24-66 Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show idical Examiner must be notlified at MD PGeoCo Laurel ty Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 20707 900-5th Street Apt 6 USA death Funeral tems! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmeth. Compl College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Munt Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Harris Ronnie Moon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900-5th Street Apt 6 Laurel, Md 20707 Wife Denise Moon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 6-11-05 Clinton, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bell Funeral HomeP.A. 21. Signature of Funeral Service 6503 Old Branch Ave. Temple Hills, Md 20748 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. art. Enter the disease, or nock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the burial-transit certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) bed f ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Chronic Alcoholism 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 🗵 es 2 🗆 No 1X Yes 2 No il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 XYes 2 □ No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? uneral 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending M 1 Tes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME 2005 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) 2005 JUN 1 0

32. Registrar's Signature

www.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Day **Physician** 2110 2005 1ac /Medical 4b. City, Town, or Location of Death Ac. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Blac oad If Under 1 Year If Under 24 Hrs. reek orchester water 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 MM 2□F Hours Min Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 32 1622 2 or Items 23a Road Kwater Funerai 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2☑No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOLOCK Rudell Ermit Manamara ပ Doris Lenora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 247-Blackwater Rd, Church Creek MD, And Date 20c. Location - City of Town, State Department of Health a Important: If item 27 Is any Injury or other tre Once. Kudell MOIOCK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Linas Rd. Cometery 4/05 Church * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.
510 Washington St. Cambridge 21. Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sicicle cell disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE esn 9 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2**X** No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 ☐ Yes 2 🛣 No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation nours after death nerel Director: / filled in by the f 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier i 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print)

ATF 2AL 300 AURO RA ST, CAMBRIDGE MO-21613 MUHAMMAD 32. Register's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State of Maryland / Department Certificate		ental Hygien	2005 20201
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1
	/Media	al	JEFFERY GEORGE NICHOLLS 4a. Facility Name (If not institution, give street and number) 23 4b. City, T	own, or Location of Death	June 4	ay 2005 1201 H M c. County of Death
4	Examir	ier		erstown		Vashington
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year	9 Birthplace (State or Foreign
	Director		215 - 90 - 7520 17 M 2□F 37 Yrs. Months Usual Residence of Decedent		Dtc. 1,190	67 MO.
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits
	e Mar Sa-f st	ctor	Md. Washington Hagerstown	<u> </u>		1 Yes 2 No
	with th	Dire	106. Street and Number 10824 DOWNSVILLE PIKE April 23	Code 21740		litizen of What Country?
	death with the Maryland ms 23e or 28e-f show rmust be notified at	Funeral Director		ent of Hispanic Origin? (Sperfy Cuban, Mexican, Puerto F		14. Race - American Indian,
9	or ite	/ Fur	1 Never Married 2 Married 1 Yes 2 No	,	Rican, etc.)	Specify: WHITE
5-0036	hours after turel', or ite	ed by	3 Widowed 4 Divorced Year or Dates:		165	
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and	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. item 27 is marked other than "neturel", or items 23e or 28e-1 show other traumatic event, the Medical Exertirer must be notified at	Be	17. Father's Name (First, Middle, Last) GEORGE DAVID NICHOILS		(First, Middle, Maide	
Maryland	2 should be and Mental Is marked or aumatic ev	ို				Or Town, State, Zip Code) 21740
	1 and 2 Health a tem 27 is		FRANCES Mae Nicholls 10824 DOL			Hagerstown Md.
Baltimore	ges 1 a t of He If item or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name or emetery, crematory or off	ner olace)		Locati City or Town, State
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Ba	permit. Departr Importu any inj		Sterry Z.	Address of Fallity FUNG ROLLINS F Sount ST	FRED HRIC	k mo 21701
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only/one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	d to He	ad	Onset and Death
	/Medical Examiner		resulting in death) Sue to (or as a consequence of):			
		ıer	Sequentially list conditions, if any, feating to minimizate gause. Enter Underlying			
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.O. B	the att	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (spe 9 Unknown 9 Unkn			Month Day Year
<u>α</u>	res that the de igned by the a be detached f	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying car	use given in Part I.	23e. Did tobacco	use contribute to the cause of death?
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Records,	~ 0.75	Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical exampler? 1 @Ves 2 \subseter No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death Other:	^	C DOther (Conside)
οl	g Phy er this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28	4 Nursing Hori	ne 5 Residence 8d. Describe how inju	
sior	Attending r death, sctor: After y the fune	catio	2 Accident investigation June 4 2003 1201 PM	1 ☐ Yes 2 ☑M6	self in fli	ite & gunshot
Division of	or Atl after d Direct in by	Certification:	4 Homicide determined determined building, etc. (Specify)	office 2	8f. Location (Street a	and Number or Rural Route Number,
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred a	t the time, date and place, a	nd due to the cause(s) and manner as stated.
	the Ho iin 24 I the Fu	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in and manner stated.	n my opínion, death occurre	d at the time, date ar	nd place, and due to the cause(s)
	To To	2	29b. Signature and title of certifier	C-1062	29d. Da	ate signed (Month, Day, Year)
			38 Name and address of person who completed cause of death (Item 23a) (Type, Print)		Hasasi	4, 2005
1-5	1+1		Fowar & W. DEHOTTIN 19,011 Orchan	Stenou 1	Hasensk	017 (40)
	Sta		31. Date filed (Month, Par Yell 6 2005 32. Refistrar's Signature B. South		•	XITT
li:	Registi	ar	James N. Warne			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** JAND 9:30 AN June 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b_City, Town, or Location of Death Examiner SHADY HOSPITAL KOCKVILLE MARYLAND MONTGOMERY GROVE ADVENTIST If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 MM 2□F NONE Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examinational Legical Item and Once. 10a, State 10b. County 1 Yes 2 No ROCKVILLE Completed by Funeral Director MONTGOMER' 10g. Citizen of What Country? 10f. Zip Code 2085 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Meiden Sumame, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) HIGHWOOD KOAD ATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F 3 □Removal from State MORGANTOWN JULY 13,05 CLE 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MEDICAL 01 23a. Part1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 24 hours De to (or as a consequence of): /Medical Examiner TESPITATON INSUFFICIENCY
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): hypertensin Division of Vital Records, P.O. Box 68760 attending physician Extreme prematurity Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Intrautaine growth retardation Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Oliquna pulmoney intershipal emphy stona. thembout penis 1 Yes 22
26. Place of Death (Check only one) 1 Tes 25. Was case referred to medical examiner? To the Funeral Director: After this certific completely filled in by the funeral director. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 13, 2005 D50902 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) Medical Center Driva Rockville, Maryland A Kimberly Iafulla 9901 20850 State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State of	Marylar			of Health a of Death	and Me		giene	005	20296
	Physici /Medi		1. Decedent's Name Philip	(First, Middle, La	st)	Pea	ır				2. Date of Dea Month May	31 Pay	2005	3. Time of Death 5:10P. M
	Examir		4a. Facility Name (If I Suburban	_		ber)		-	m, or Location o	of Death			ounty of Deat	
	Funeral Director		5. Social Security Nu 578–18–40	88	Sex 7 1X M 2□F	. Age (In yrs.	last birthday) 5 Yrs.	If Under 1 Y Months D	ear If Under and Hours	Min	B. Date of Birt. (Month, Day April	7, 19	Co	hplace (State or Foreign unitry) hington, D.C
	yland ow		Usual Residence of I	10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	99-f st	ctor	Maryland	Montgom	ery		Bethes	da						1 ☐ Yes 2 📉 No
	th with th 23a or 24	Funeral Director	10e. Street and Num 8000 Aber		đ			10f. Zip Co	20814				en of What Co ted Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; if item 27 is marked other than "natural", or items 23e or 28e-f show and portant; if item 27 is marked other than "natural", or items 23e or 28e-f show any portant; if item 27 is marked other transmatic event, it is Marileal Examination in the mariled at once.	by Funer	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Deced Armed Ford 1XXYes 2 If Yes, Give	es?		Was Decedent If Yes, specify 1 ☐ Yes 2	of Hispanic Orig Cuban, Mexican No Specify:	gin? (Speci n, Puerto Ric	ify Yes or No- can, etc.)		Black, White	
21215-0036	72 hour	leted t		15. Decedent's E fy only highest gra	ducation	es: WWII	(Give	dent's Usual O	one durina most	t of working	,	16b. Kind	of Business/	
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Maryland	and 2 should eath and Men n 27 is marke	Ě	19a. Informant's Nan Muriel Mi				19b. Mailir 8000	ng Address (St. Aberdee	reet and Numbe n Road	r or Rural F Bethe	Route Numbe	r, City or 1 aryla	Town, State, Z	ip Code)
Baltimore,	Pages 1 and 2 ent of Health nt; If item 27	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) King David Mem. Gardens 6/3/2005											ation - City or	Town, State
Balti	permit. Pages Department of Important; If it any injury of once.		21. Signature	1	See Contraction	thes	1 D	Name and A	dress of Facility	ardt '	Funera	1 Hon	ie Di	
)	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of):											e, Mai	Approximate Interval Between Onset and Death
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Vital	Phyaician: this certific ral director.	o Be	25. Was case referre examiner? 1 ☐ Yes 2 🔀 N	·	Hospital:	atient 2 🗆	ER/Outpatien	3 DOA	26. Place Other: 4 Nur		Check only on		70ther (Case	7. 1
on of	ting I. After Iune	tlon: T	27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending	28a. Date of (Month,		28b. Time of Injury	28c. I	njury at Work?	280	d. Describe ho			119)
Division	i Dir	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of	Injury - At ho , etc. (Specify	me, farm, stre	eet, factory, off	се	28f	Location (SI City or Town		Number or Rui	ral Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 (Check only 2 one)	X Certifying Ph	ysician: To the basiner: On the basiner and manne	s of examinat	wledge, death ion and/or inv	occurred at the	e time, date and ny opinion, death	place, and	d due to the ca at the time, d	ause(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)
		Me	29b. Signature and tit	tle of certifier)			29c. Lic D58	ense number 1681				igned (Month)	-
	35		30. Name and address	ss of person who	.D. 8600	of death (Item	23a) (Type, F	Print)	2 D-11	- 7				
	Sta Registr	-	31. Date filled (Month,	B D DOO	5 2. Reg	istrar's Signal	ure Jose	WII KOA	u <u>bethe</u>	sda,	Maryla	nd 20	814	
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PEAR, PHILIP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Irene mae 1139 mai 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Jomers SILVEY Spring mond 15/00 Interlacken Dr 326 8. Date of Birth (Month, Day, Oct. 23 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1924 Days Months Hours 578-36-1273 Virginia 80 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Evantiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥ Yes 2 □ No Funeral Director Silver Spring Maryland Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 15100 Interlachen Drive # 326 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Negro Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Volunteer Art Museums 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Belgrove Road, McLean, Virginia 22101 Claudine Malone / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6/7/05 Washington, D.C. Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Fulleral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASCVID Examiner Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the hundstrand. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown <u>م</u> 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Stesidence 6 Other (Specify) 1 Yes 2□ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

10 00428

29d. Date signed (Month, Day, Year)

20902

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State Registrar

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/0/ me Ical Park

IRA N BRECHER, MD DME Scluer Spring MD

31. Date filed (Month, Dav. Year) 31. Date filed (Month, Day, Year) 3. Registrar's Signature JUN 03 2005

Ker m Dms

			1 - For State Registrar	State of Ma	aryland /		artmen rtificat					Reg. No.)05	2029	98
	Physici	an	1. Decedent's Name (First, Middle, Las								Date of De Month	Day	Year	3. Time of De	3.4
	/Medic	al	Lawrence Lenwood Pil				4h Cihi	Tourn	Location o	f Dooth	June	9	2005 unty of Death	1:30 A.	1
	Examin	er	4a. Facility Name (If not institution, give							n Death					
	Funeral		5. Social Security Number 6. Sec		e (In yrs. last bi	irthday)	If Under	anics 1 Year	If Under 2	24 Hrs.	8. Date of Bir (Month, Da		9. Birth	place (State or F	Foreign
	Director		216-22-2936	X M 2□F	74	Yrs.	Months	Days	Hours		(Month, Da			intry) y1and	
	p ,		Usual Residence of Decedent		10c. City, Tov									40d Inside City	1.1
	shov	-	10a. State 10b. County											10d. Inside City I	
	28a-f	Director	Maryland St. Mary' 10e. Street and Number	S	Mechai	nicsv	7ille 10f. Zip	Code				10g Citizer	of What Cou		
	with with	2	27870 Old Village Roa	d			101. 2.0	20659	·			U.S.		andy:	
	Jeath The 23	by Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. \	Was Dece	tent of Hi	spanic Orio	gin? (Spec	ify Yes or No		Race - Amer		-
9	or Ite	교	1 ☐ Never Married 2 🙀 Married	Armed Forces? 1 ☐ Yes 2 K N	10		If Yes, spec 1 ☐ Yes	-	n, Mexican Specify:	, Puerto F	tican, etc.)		Black, White		
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28e-f show he Medical Examiner mas Le rolling a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:								Sp	ecify: Whi	.LE	
2	"natu	Completed	15. Decedent's Ed (Specify only highest gra-		168	(Give	dent's Usua kind of wo DO NOT us	rk done d	turing most	t of workin	g	16b. Kind	of Business/li	ndustry	
12	withir ene than	E G	Elementary/Secondary (0-12)	College (1-4or 5			Mechar		/			пе	Govern	mant	
	filed Hygi other	ပိ	8 17. Father's Name (First, Middle, Last)			1000			18. Mothe	r's Nam <i>e</i>	(First, Middle			mcne .	
<u>a</u>	lid be lental ked c	To Be	William Archie Pilker	ton					He1e	n Mae	Wood				
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic event, the Med		19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailir	ng Address	(Street a	and Numbe	r or Rural	Route Numb	er, City or To	own, State, Zi	ip Code)	
	and 2 ealth n 27 i		Lucille Elizabeth Pil	kerton/Wife	27	7870	Old Vi	11age	Road,		anicsvil				
Baltimore,	Pages 1 nent of H. ent: If Iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place o	of Dispo ery, cren	nsition (Nar matory or o	ne of ther plac	θ)	Di	ate	20c. Locat	ion - City or T	fown, State	
Ë	tmen tmen tent:		`4 □Donation 5 □Other (Specify		St. Jos						3,2005	Morganz	a, Mary	1and	
Ba	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show amportent: or other traumatic event, the Medical Examinar must be routilised at 900e.]	21. Signature of Funeral Service Liber	way_			Name an			Mat	tingley- own, Mar		r Funer 20650	al Home, I	P.A.
L	enysician /Medical		23a. Pan. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Meta	shitic	Lon	er the mod		g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Dea	ath
И	Examiner				a consequence	9 017.									
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequence	of).									
/_	cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as a	a consequence	of):									
8760,	siclen buria	cal E		,	·	•									
687	tificate ig phys as the	edic		. d											
Вох	deeth certificate be executed e ettending physicien and id for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		h 3□	Ectopic pr	eonancv				230	. Date of deliv	•	
0		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5	Other (sp	ecify)					Month	Day Yea	#I
<u>α</u>	iaw requires thet the de as been signed by the 6 2 should be detached 1		Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the u	nderlying c	ause give	en in Part I.		23e. Did 1	obacco use	contribute to	the cause of dea	ith?
rds	quires n sign	d by									1 🗆	Yes 2□N	lo 3□Pro	bably 4 Unk	<nown< td=""></nown<>
S	aw require is been sig 2 should b	Completed									24a. Was		4b. Were aut	opsy findings ava	ailable
Re	The lay	omp									auto perfo	psy prmed? 2ZNo	death?	ompletion of caus	se of
Vital Records,		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	, ,			
of <	Physicien: this certific ral director,	Tof	1 Yes 25 No	Hospital: 1 ☐ Inpatie		utpatien	nt 3 DC	Othe	er: 4 □ Nu	rsing Hom	e 🕉 Resi	dence 6	Other (Speci	ify)	
on c	Attending P r death. sctor: After t by the funera	tlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	f 2	8c. Injury Work 1 🗆 `	rat ⊲? Yes 2 🗆 I		8d. Describe	how injury o	ccurred		
Division	ofter des Director In by th	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc		arm, str	eet, factory	, office		2	8f. Location (City or To		lumber or Rur	ral Route Number	τ,
	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	dical C		ysician: To the best of the basis of and manner sta	examination a										
	To the	Me	29b. Signature and title of certifier					. License				29d. Date s	igned (Month	, Day, Year)	
}	> 0		160lan				1	050	666			6/9	1 /05	>	
			30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type,	Print)	17	LEON	ARD	NWOT	MO	2065	0	
	Sta Registi		31 Date filed (Month, Day, Year)	2005 32. Fraistra	ar's Signatur	A	forte	,							

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar		State of Ma	iryland / L	-	rtment of H tificate of L			gienę Reg. No.:	2005	20299
			1. Decedent's Name (F	irst, Middle, Las	t)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Robert Lee	Powell	Sr.					May	_28	2005	12:39 Pm
}	Examin	_	4a. Facility Name (If no	at institution, give	street and number)			4b. City, Town, or	Location of Dea	th /	4c.	County of Death	
			Washington					Hagersto				shingtor	
	Funeral		5. Social Security Num	1	ex 7.Age M∑M 2□F	(In yrs. last bii	thday) L Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ıy, Year)	Cour	**
	Director	-	216-22-825 Usual Residence of De			76				May 12,	1929	Mary]	and
	nand ow			0b. County		10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits
	Man)	ō	Maryland W	ashingt	on	Hagers	tow	n					1 ☐ Yes 2X No
	h the	lec	10e. Street and Number					10f. Zip Code			10g. Citi:	zen of What Cour	ntry?
	th wit	aD	20415 Highv	view Ct.				21740			U.S.	A.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hydione. If them 27 is marked other than "naturel", or Items 23a or 28a-f show or other treumatic event, it a Marilcal Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 [12. Was Decedent I Agmed Forces? F Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. Io	1	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.))-	14. Race - Americ Black, White, Specify:	
ğ	2 ho	ted	15 (Faccity	5. Decedent's Ed	lucation	16a	Deced	ent's Usual Occupa	ation	orkina	16b. Kii	nd of Business/In	dustry
7	within 7 ene. than "r	Completed by	Elementary/Seconda		College (1-4or 5		life. L	OO NOT use retired)	J.Kaig			
7	e filed within al Hygiene. I other than vent, it a Me	Con	12				Sale	sman				itutiona	1 Foods
n D	be fill tal H d oth	Be	17. Father's Name (Fir	_	_					ime (First, Middle			
<u>\Z</u>	should be nd Mental nmarked umatic ev	2	Walter Jame 19a Informant's Name			101	Mailin	g Address (Street	-	Lily (Ru			(Code)
Maryland	id 2 st ith and 27 is n treun		Mary E. (Mur	, ,		1-		Highview					(0006)
	1 and Health tem 27		20a. Method of Dispos		WCII/ WIIC			sition (Name of natory or other place	40	Date		cation - City or To	own, State
Baltimore,	Pages 1 an nent of Heal ant: If Item 3 ary or other		1 Burial 2 □0		Removal from State			natory or other plac 1 Cemeter		2,2005	lager	etown l	MD
=	コモモラ .	1	21. Signature of Fune			rest II		. Name and Addres					
æ	Depar Impo any ir		K,	4/	7.			01 Penns					
			23a, Part1. Enter the	disease, or com	plications that caused one cause on each lin	the death. Do							Approximate Interval Between
	Physician		Immediate Cause (Fir		orie cause on each in	Cash	ax	oscano	Later C	28016	2		Onset and Death
	/Medical		disease or condition resulting in death)	-	a Due to (or as	a consequence	of):	esma	any c	cow,			
	Examiner		O		h	acert	7	respira	bory fo	riline			
	n =	ner	Sequentially list condi- if any, leading to imme cause. Enter Underly	ediate ing	Due to (or as	a consequence		• 0 0	7	1			
	ecuted ind trans	Examiner	Cause (Disease or inju- that initiated events resulting in death) Las	ury	c	Hahrs	p	off Em	pycina	- drain	age		
Ö,	oe execian a	E	resulting in death) Las	"	Due to (or as	a consequence	OU:		7 diana		4		
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical			dE	ud W	afl	yena	MORO	OKC			
	ding		IF FEMALE:		23c. If yes, outcome	of pregnancy						23d. Date of delive	erv
Вох	death certi e attending ed for use a	Physician/M	23b. Was decedent print the past 12 mg	onths?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)			- 1	Month	Day Year
0	at the de by the intached	ıysi	1 Yes 2 N 9 Unknown	10	9□ Unknown								
<u>α</u>	de ad	by Pr	Part II. Other significa	ant conditions	ontributing to death b	ut not resulting	n the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
rds	quires n signe uld be			ll	yperde	aslar				1 🗆	Yes 2	□No 3□Prob	pably 4 Dunknown
000	aw require ts been si 2 should t	olete			/ *					24a. Was		24b. Were auto	psy findings available impletion of cause of
æ	0 5 0	ompleted								auto perfi 1 Tyes	ormed?	death?	
Vital Records,	icien: Th certificate rector, pag	Be C	25. Was case referred	d to medical					The second secon	eath (Check only	one)		
f V	§ ≅ ⊒	To E	examiner?)	Hospital: 1 7 patie	ent 2 ER/O	utpatien	t 3 DOA Oth	er: 4 Nursing	Home 5□Res	idence	6 □Other (Specia	(y)
n of	ding Ph h. After th funeral	iuo	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ry 28b. y Year)	Time of Injury	Wor		28d. Describe	how injur	y occurred	
<u>S</u> i	ttendin death. ctor: A y the fu	catl	2 Accident	investigation					Yes 2 □ No				
Division		Certification;	3 Suicide 4 Homicide	determined	28e. Place of Inj building, et		arm, str	eet, factory, office		28f. Location City or To		d Number or Rura)	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in E	edical	29a. Certifier 14 (Check only 2 one)	Certifying Ph Medical Exar	ysician: To the best niner: On the basis o and manner st	f examination a	e, death nd/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death oc	ce, and due to the curred at the time	cause(s) , date and	and manner as s place, and due to	stated. o the cause(s)
	To th Withir To th	ž	29b. Signature and tit	le of certifier	Pulivail	r. MD		29c. Licens	e number	2	29d. Dat	e signed (Month,	Day, Year)
			> 0h	mo					20233	1	21.	4105	
			30. Name and addres	s of person who	completed cause of c	leath (Item 23a)	(Туре,	Print)	// /	11 -1		44 0	
45	5+1		BAPURAC	PULL	ARTI, MI	129	31	Oakhil	(-Ave,	Hagerst	mn ,	max 21	142
	Sta Registi		30. Name and addres BAPURAC 31. Date filed (Month)	UN 0 6	32. Registr	ars Signature		1					
	negisti	ell.			Mirle	we so.	D	ever					

ORIGINAL

			1 - For State Registrar		State of Ivi	arylari		rtificate of		d Mental Hy	/giene Reg. No.	JUJ	20300
ı	Physici		1. Decedent's Name (First, Middle, Las Irene	Richar	ds				2. Date of D Month MAY	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If no			~		4b. City, Town, o	r Location of D	•	30	County of Death	10:40 P M
	Examili	ier	UNIVERSI	-02	1 . 1	11		,			46. (County or Death	
	Euporol		5. Social Security Num		pecitlicte	e (In vrs. I	astibirthday)	If Under 1 Year	If Under 24		irth	0 Rietho	lace (Chate on Forming
	Funeral Director		216-40-57	02	□M 247F	62	Yrs.	Months Days		Ain. (Month, D	ay, Year)		ilace <i>(S</i> tate or Foreign itry) yland
	yland now		Usual Residence of Di 10a. State 1	ob. County		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	Be-f sl	Funeral Director	MD	Calver	t			Lusby					1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Numb					10f. Zip Code			10g. Citiz	en of What Coun	itry?
	s 23	era	810 White	e Sands		E	2 1 12	20657				USA	
36	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "naturel", or items 23a or 28e-f show event, I've Medical Evanting must be routled at	by Fun	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 [12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			was Decedent of H If Yes, specify Cuba 1□Yes 2☑No		? (Specify Yes or N uerto Rican, etc.)		Race - Americ Black, White, (Specify:	etc.
-00	2 hou	ted !	15	5. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	ation		16b, Kin	wh:	
21215-0036	filed within 7: Hygiene. Ither than "n	Completed	(Specify Elementary/Second	only highest gradery (0-12)	de completed) College (1-4or 5	i+)		dent's Usual Occup kind of work done DO NOT use retired	during most of d)	working			addity
	illed Hygi other	Be C	17. Father's Name (Fil	rst, Middle, Last)	-		TIOTE	enaker	18. Mother's	Name (First, Middle		wn home	
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, Lie M	To B	Elmer A	rthur	Moreland				Mildre	ed Fran	ces	Smith	
Jar	a se se		19a. Informant's Name	e/Relationship (7	уре, Print)					r Rural Route Numb		Town, State, Zip	Code)
	other tr		James E.]		on	20h B			nds Driv	ve, Lusby		20657	
Baltimore,				Cremation 3 🗆	Removal from State	CE	emetery, crei	sition (Name of natory or other place	· ·	Date		ation - City or To	
äŧi	++++		21. Signature of Fune			Cen		Cemetery 2. Name and Addres		-04–2005	Bar	stow, MI)
ä	Dep- Imp- any		· ille	ian R	Gra-					lome, P.A		wings, M	D 20736
				allure. List only o	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dyin	ig, such as care	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	1	Immediate Cause (Fir disease or condition resulting in death)	181	d	relie		draythe	mias			1	30 miniles
ı	Examiner				Due to (or as		,	c hoom	1- dis	ease			leigrig
	p #	iner	Sequentially list condition in any, leading to immediate. Enter Underlyi Cause (Disease or injusted)	diate ing	Due o (or as								7
	secute and I-trans	Examiner	Cause (Disease or inju- that initiated events resulting in death) Las		c. Due to (or as	a consocu	unnen af\:						
68760,	icate be executed physician and s the burial-transit				d	a consequ	iorico di).						
	rtificate ng phy as the	Medic	IE EENAL C		d								
Вох	eath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pr in the past 12 mg	egijani	23c. If yes, outcome 1□Live birth			Ectopic pregnancy			23	3d. Date of deliver	*
P.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	1 Yes 2 M 9 Unknown		4□Pregnant at 9□Unknown	time of de	ath 5□	Other (specify)				Month	Day Year
	es that igned b be deta	by Pt	Part II. Other significa								tobacco us	e contribute to the	e cause of death?
ords	w require been sig should b	ted t			enal dis						Yes 2□	No 3□Proba	abiy 4 Unknown
Records,	law ras be	Completed	Chronic	OBSM	ctive Li	my c	ilseas	e on ve	enhilaten	24a. Was		24b. Were autop	sy findings available
al H										perfo 1 ☐ Yes	2 No	death?	/
Vital	Physicien: r this certificated director,	o Be	25. Was case referred examiner?		Hospital:			Oth		Death (Check only			
of	Phys rr this aral di	-	1 Yes 2 No	-	28a. Date of Injur		ER/Outpatien 28b. Time of	t 3 DOA	4 ☐ Nursin	g Home 5 ☐ Resi 28d. Describe	how injury	Other (Specify,)
ion	utending I death. ctor: After y the funer	atior	1 □Natural : 2 □ Accident	5 ☐ Pending investigation	28a. Date of Injui (Month, Day	Year)	Injury	28c. Injun Work M 1 🗆 '	k? Yes 2 □ No	200. 2000. 20	now anjury	00001100	
Division	ire ire	Certification:	3 ☐ Suicide 4 ☐ Homicide	Could not be determined	28e. Place of Injubul	ry - At ho	me, farm, str	eet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rural	Route Number,
	To the Hospital within 24 hours at To the Funeral Completely filled in	Medical C	29a. Certifier 1[(Check only 2[one)	Certifying Phy Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at the time vestigation, in my op	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) a date and p	nd manner as sta place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title	of certifier				29c. License	number		29d. Date	signed (Month, D	Day, Year)
)				- Marie Contraction of the Contr	KNES	141.		D	30490	4	5/3	11/05	
	n		30. Name and address		ompleted cause of d	eath (Item		Print)					
_	χ				oth chan					10 0/430	3		
	Sta Registr		31. Date filed (Month,		32. Registr	s Signat	ure M	South D					

RICHARDS

				partment of Health and Mental H	•
			1_ State	ertificate of Death	2.000 2.13111
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No. Death 3. Time of Death
	Physici		Mary Margaret	Schroyer June	Day Year 9 2005 5:27 A ^M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Exami	lei	Frederick Memorial Hospital	Frederick	Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		irth 9. Birthplace (State or Foreign Country)
ь	Director		214-28-1005 1 M 2 M F 83 Yrs.	Months Days Hours Min. (Month, D	6, 1922 Maryland
	pu >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Looking	10d. Inside City Limits
	shov	'n		derick	1 ☑ Yes 2 ☐ No
	28a-f	ect	10e. Street and Number		, and the second
	with	급	2100 White Hall Road, B-A	10f. Zip Code 21702	10g. Citizen of What Country? U.S.A.
	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show ite Mudical Exercines mastite notillied at	Funeral Director			
10	r iten	E	1 Never Married 2 Married 1 Yes 2 No	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	Black, White, etc.
03	al', o	þ	3 ⅓ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2√€ No Specify:	Specify: White
21215-0036	72 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation	16b. Kind of Business/Industry
21	ithin 19.	npie	Flementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working a. DO NOT use retired)	
	filed with Hygiene. Ither than	ပ္ပ		omemaker	Own Home
and	be fi	Be	17. Father's Name (First, Middle, Last) Alonza Fox	18. Mother's Name (First, Middle	
Ž	2 should b and Menta is marked raumatic e	2		Nannie	Fox
Maryland	d 2 st th and 7 is r traur			ailing Address (Street and Number or Rural Route Num	
	1 an Heal tem 2 other			O White Hall Rd, B-A, Fre	20c. Location - City or Town, State
JO L	Pages nent of I int: if its		1X Burial 2 □ Cremation 3 □ Removal from State 1X Donation 5 □ Other (Specify) 1X Donation 5 □ Other (Specify)	et Cemetery Jun 13, 2005	Frederick, Maryland
Baltimore,	# 문학구		21 Signature of Funeral Service (C. n.ce	22 Name and Address of Facility	, ,
ä	Deported Important		Hollym Kobem M00706,	Keeney & Basford P.A. I 106 Fast Church St. Frede	Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or hear failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between
	Physician :		Immediate Cause (Final disease or condition	hemic Carleonie	Onset and Death
	/Medical		resulting in death) Due to (or as a con squence of):	0 / 1	July Jean
	Examiner		Sequentially list conditions b	rary Ortery Dis	eas years
1	be iis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
•	and I-tran	хап	that initiated events resulting in death) Last C		
760,	ate be executed nysician and he burial-transit	caiE	225 15 (31 25 25 31 105 25 31 15 37 1		
687	ficate p phys s the		d		
ŏ	eath certificat attending phy I for use as the	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
m	death e atte	icia	in the past 12 months? 1 Ver 3 Mes	3 Ectopic pregnancy 5 Other (specify)	Month Day Year
P.0	at the by th tache	Physician/Med	9 □ Unknown		
ŝ	The law requires that the death certifica ite has been signed by the attending phoage 2 should be detached for use as the	by F	Part II. Other significant conditions contributing to death but not resulting in the	, , , , , , , , , , , , , , , , , , , ,	tobacco use contribute to the cause of death?
Records,	w requir been s should	Completed	Dearens	1	Yes 2 No 3 Probably 4 Unknown
ec	e law i has b	ηpie		24a. Wa aut	opsy prior to completion of cause of
		Co		per 1□ Yes	formed? death? 2 No 1 Yes 2 No
Vital	ysician: Thi is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	one)
of	Phys this ral dii	1.	1 ☐ Yes 2 No Prospital: 1 ☐ Inpatient 2 ☐ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time	1910	sidence 6 Other (Specify) how injury occurred
UQ	ding h. After fune	tion	1 Natural 5 Pending (Month, Day Year) Injur	y Work? M 1 Yes 2 No	Thow injury occurred
Division	i or Attendi after death. Director: A	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm.	street, factory, office 28f, Location	(Street and Number or Rural Route Number,
Ö	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or To	own, State)
	papita hours inera y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
	To the Hoapital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral complexes the force of the funeral complexes the force of the funeral filled in the funeral complexes the force of the funeral filled in t	Medical	(Check only 72 Medical Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurred at the time	a, date and place, and due to the cause(s)
	With To I	Σ	29b. Signatural and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•			MILTON	DZ6310	JUNE 7 7063
	2		30 Name and address of person who completed cause of death (Item 23a) (Type	De, Print AUS ALE FORA	IND 2/707
	Sta	to	31. Date filed (Month, Day, Year) 1005	NINCT IVE TOELD	1100
	Registr		JUN 1 7 2005		

ey	Seaton		1 - For Stete Registrar	State of Man		artmen					iene	U5	20	302
			Decedent's Name (First, Middle, La	ist)				_		2. Date of Deat	h		3. Time o	f Death
	Physicia	an		Seaton						Month	Day 20	Year	, 17	\mathbf{p}^{M}
	/Medic		4a. Facility Name (If not institution, given			4h City	Town or	Location of	of Death	June	4c, Count		4:17	P
	Examin	er						Coodion	or ocum			,		
_			Bowie Health Cent 5. Social Security Number 6.5		(In yrs. last birthday	BOW1		If Under	24 Hrs.	8. Date of Birth	Princ	9. Birth	place (State)	or Foreign
н	Funeral Director		575-47-2002	1□M 2XF	17 Yrs.	Months	Days	Hours	Min.	June 19	. 1987	Mar	yland	
			Usual Residence of Decedent								,			
	yland		10a. State 10b. County		Ioc. City, Town or L	ocation							10d. Inside C	
	Mar Mar	to	MD. Prince (George's	Bowie								1 ØYes	2 □ No
	r 28g	irec	10e. Street and Number			10f. Zip	Code			10	og. Citízen of	What Cou	intry?	
	3a o	Funeral Director	12205 Rolling Hi	ill Lane			20	0715			USA			
	ms 2	Jer	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Deced	tent of H	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)			ican Indian,	
9	after or Ite	F	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No					i, rueito	nican, etc.)		ck, White		
8	all, c	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 Tes	ZA NO	Specify:			Specil	y: Wh:	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Then then "natural", or items 23a or 28a-f show shift the Macifical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation a de completed)	16a, Dece	edent's Usua kind of wo	al Occupa	ation during mos	t of work	ing	16b. Kind of B	lusiness/li	ndustry	
7	B e .	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us)			~ 1	-		
7	Agien Agien	Co	9			Stude	ent				Sch			
D D	al Hy d oth	Be	17. Father's Name (First, Middle, Last							e (First, Middle, M	faiden Sumai	ne)		
<u> a</u>	Ment Ment Ment arked	2	Michael K. Seat	on				Ga	le Y	ates				
Maryland	and and ls my		19a. Informant's Name/Relationship							al Route Number,	-			
≥ .	s 1 and 2 and Health an item 27 Is		Michael K. Seato	n / father		5 Ro13		Hill			e, MD.			
ore	of He iter		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Disp cemetery, cre	osition (Nan matory or o	ne of ther plac	e)		Date 2	20c. Location	- City or T	own, State	
Ĕ	Pag nent ant: I ury o		`4 □Donation 5 □Other (Speci		Metropol	itan (Crema	atory	06/	07/2005	Alexa	ndria	a, VA.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I have constructed to the result in marked other than "natural", or flems 21a or 28a-f show any injury or other traumatic avent. The Madical Examinar must be notified at once.		21. Signature of Funeral Service Lice	nsee A	2	2. Name an	d Addres	s of Facilit	by Be	all Fune	ral Ho	me		
m	89 5 2 8		Buan	Youell	6	512 N	V Cra	ain H	wy.	Bowie,	MD.	20715	5	
	nysician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	consequence of):		≯ø]	L.	L	or respiratory arre	si,		Approximal Interval Bel Onset and	tween
68760,	certificate be executed nding physician and use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):									
B	death e atter ad for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 → es 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	□Ectopic pr □ Other <i>(sp</i>						ate of delive		Year
ds, P	es the	þ	Part II. Other significant conditions	contributing to death but	not resulting in the t	underlying c	ause give	en in Part I		23e. Did tob	acco use con s 2 □ No	tribute to t		death? Unknown
Record	e law requir has been s je 2 should	ompleted								24a. Was ar autopsy perform	/	Were auto prior to co death?	opsy findings empletion of a	available ause of
	ate pag	ပ္ပ										1 Yes	2 No	
Vital	yaician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death	n (Check only one)	`		
5	χ	ို	1 X Yes 2 □ No	1 inpatient	2 ER/Outpatie			4 140	-	me 5 Reside			fy)	
_	ding F	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time o	of 2	8c. Injury Work	rat C?	,	28d. Describe ho	w injury occur	red		
Division of	Attending in death. actor: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be	I SECR CILLO		32H2	1 - 1	Yes 2		serp 4	part .		-10	1
Ξ.	or Attendeate Director:	E	4 Tromicide determined		- At home, farm, st (Specify)	reet, factory	, office			28f. Location (Str City or Town	State) 3	OBT OF HUI	A House Num	s.h. Ton
	ital o	0		trakon	worded	perh			- 1	Bon	el, Mas	7/00	ed	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only 2X Medicel Exe	hysicien: To the best of miner: On the basis of e	xamination and/or in									5)
	To the within 2. To the I complete	Med	20h Signature and title of partifier	and marringr state	d)	200	Licence	number		20	ld. Date signe	d (Month	Day Year	
	To wit	~	29b. Signature and title of certifier	10		290	OCI			25	vale signe			
	(1)		Theoden M	1. frya	us		, , , ,			Jı	ine 2	200	5	
R	(3)		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	. Print) 111	Per	ın St	reet	Baltim	ore. M	arv1s	and 212	201
T			THE WONE MIKE	9	- Ci						, -1			
	Sta Registra	-	31. Date filed (Month, Day, Year)		s Signature	ale								

			For State Registrar	State of Ma	aryland		artment tificate			and Me		giene Reg. No.	2005	20	303
	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, BETY W. 4a. Facility Name (If not institution,	3MIT1	H		4b. Çity,	Town, or	Location o		2. Date of Dea	30ax	Year 200	5 8	e of Death
	Funeral Director		OASTAL HOST	PICE ATT	HE 1 e (In yrs. Ia 77	AKE ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birtl (Month, Day 2/27/19	7, Year) 928		M/C thplace (Stabuntry) ngland	O ate or Foreign
Maryland	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicon	ico		Town or Lo									e City Limits Yes 2 ☐ No
with the	a or 28	Dire	10e. Street and Number 412J Woodview S	quare			10f. Zip	Code 1804				-	zen of What Co SA	untry?	
III C 7 7 1 2 10-0000 be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent; or items 23a or 28e-f show Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Madical Exertinet must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces?		j		ent of His ify Cubar		gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit		٦,
vithin 72 hou	ne. han "neture s Madical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	5+)	life. L	kind of wor DO NOT us	k doné d e retired)	u <i>ring mosi</i>	t of workin	g	16b. Kii	nd of Business	Industry	
o filed v	Hygie other t	Be Co	17. Father's Name (First, Middle, La	4		Repr	esent			r's Name	(First, Middle,	Maiden	Union Sumame)		
al ylal should b	d Menta narked natic e	ToE	Thomas Richard 19a. Informant's Name/Relationship			10h Mailie	a Address	(Street o			h Brown		Tour State	Zin Cada)	
and 2 st	alth and		Phyllis G. Hawki								Bern, N		Town, State, 2 3562	op Code)	
Pages 1 a	or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3		ce	ace of Dispo metery, cren inghi	sition (Nan	ne of ther place	9)	6/4/0	ite	20c. Lo	cation - City or		9
Dallillo permit. Pages	Departmer Importent any injury ance		* 4 □Donation 5 □ Other (Special Service Lie		Gar	dene		_	1				oron, M ional A		
ā ā	S i i d		23a. Part 1. Enter the disease, or coshock, or heart failure. List or	emplications that caused by one cause on each line	CFS the death, ne.	P 50	01 Sno	OW H	ill R g, such as	cardiac or	Falisbu respiratory ar	rest.	MD 218	04 Approxi Interval	
1	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Maligna Due to ras	a conseque	Astro ence of):	cyton	n	st		Brain	?		2 uns	inthis
	yaminer ausit	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for as	a consugue	ence of):									
icate be exec	physician and s the burial-transit	icai	resulting in death) Last	Due to (or as	a consequ	ence of):									
THE COLUMN, T.O. BOX 00/00, The law requires that the death certificate be executed	been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▼ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					2	23d. Date of de Month	livery Day	Year
w requires that	been signed b should be deta	by	Part II. Other significant condition	s contributing to death b	out not resul	lting in the u	nderlying c	ause give	n in Part I.		23e. Did to		se contribute to		of death?
The law re		Completed									24a. Was autop perior 1 Yes	sy	24b. Were at prior to death?	completion	ngs available of cause of
Physicien:	this certific	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2∏E	ER/Outpatien	nt 3□ DO	A Othe	VP.	-	(Check only only only only only only only only		3 □Other (Spe	cifv)	
ding	After fune	Certification; T	27. Manner of Death Natural 5 Pending 2 Accident Investiga	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work		No 2	8d. Describe h	iow injur	y occurred		
DIVIS	s after de si Directo ad in by t	Certific	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Inj building, et	ury - At hor c. <i>(Specify)</i>	me, farm, str	eet, factory	, office		2	8f. Location (S City or Tow		d Number or Ri)	ural Route f	Number,
DIVISION To the Hospitei or Attending	within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical		Physician: To the best caminer: On the basis of and manner sta	f examinati										se(s)
To th	withir To th comp	Ž	29b Signature and title of cartifier	///	1 nd	\wedge	290	License	number	270		29d. Dat	e signed (Mont	h, Day, Yea	ir)
	2		30. Name and address of person w	no completed cause of c	death (Item	23a) (Type,	Print)	D	0	0/2	2		5-31	-03	0.
	17		DAVIDE CXLAD	LIND COX	STAL 1	40591K	E	10.	59x	173	3 Sa	1 isku	in the	11) 21	186in
	Sta Registi		31. Date filed (Month, Day, Year)	2005 See	AR J	b A	barle	,					O		

			1 - For State Registrar	State	of Marylar	•	artment rtificate			and M	-	giene Reg. No.	005	20304
	Physicia /Medic		1. Decedent's Name (First, Middle Dorothy Winona	Seibert							2. Date of De Month June	7 Day	2005	3. Time of Death 5:00 A M
	Examin	_	4e. Fecility Name (If not institution 1684 Langley D	rive #102			4b. City, To Hager	sto	wn			Wa	ounty of Death ashingt	
	Funeral Director		5. Social Security Number 220-09-7145 Usuel Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	Min.	8. Date of Bin (Month, Da 01/12/1	th y, Year) L921	9. Birth Cou	place (State or Foreign ntry) MD
	Maryland f show	jo	10a. State 10b. County MD Washi		10c. Cit	ty, Town or Lo								10d. Inside City Limits 1 Yes 2 □ No
:	3a or 28e	Funeral Director	10e. Street and Number 1684 Langley D	rive #102			10f. Zip C	217	40			_	on of What Cou	ntry?
036	o within 72 hours after death with the marylan jiene. Jiene. Tthen "naturel", or Items 23a or 28e-f show the Medical Examinar must be notified at	Ď	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	Armed F	2 📉 No ive		Was Decede If Yes, specifi 1 ☐ Yes 2		spanic Origin, Mexican	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify: Wh	
9500-61212	illed within 72 hours after death with the Maryland Hygiene. Hither then "naturel", or Items 23a or 28e-f show Int. The Medical Examinar must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	1) (1-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use erator	done d retired)	ition Juring most)	t of work	ing		of Business/In	dustry
and	e d la b	To Be C	17. Father's Name (First, Middle, Frank Clayton								e (First, Middle, t Louis		,	
=	s 1 and 2 should be f Health and Menta ftem 27 Is marked other treumatic ev	-	19a. Informant's Name/Relations Cynthia G. Mil	hip (Type, Print)	e						al Route Number			
nore,	0° = 5		20a. Method of Disposition 1 Burial 2 Scremation		State	Place of Disponentery, crea					Date 3/2005		ition - City or To	
	permit. Pages 1 a Department of Hei Important; if item any injury or othe		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	1.0	Siii	22	2. Name and	Address	s of Facility	y Gei		Minn		eral Home
	oparin certilicate be executed we attending physician and and for use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	caused the deat each line. COTTO	type of): rete quence of):	A ROL	of dying	g, such as	cardiac o	PROT	rest.	e	Approximate Interval Between Opset and Deathy Winner Co.
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta pant at time of conown	al death 3	Ectopic preg Other (spec		_			236	d. Date of delive	ery Day Year
ds, P.	w requires that to been signed by should be detac	þ	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cau	use give	n in Part I.		23e. Did to	17.00	/	he cause of death?
	Inela ate has page 2	Completed											prior to co death?	psy findings available mpletion of cause of
Vital	ysicien. is certific director	To Be	25. Was case referred to medica examiner? 1 Yes/ 2 No	Hospital	Inpatient 2	ER/Outpatier	nt 3 DOA	Othe			me 5 Currie		□Other (Specif	ýy)
Division of	or Attending Physicien: ifter death. Director: After this certifica in by the funeral director.		27. Mann of Death 1 Patural 5 Pendir 2 Accident investi	19	of Injury nth, Day Year)	28b. Time of Injury	M 280	c. Injury Work			28d. Describe I		occurred	
DIVIS	al or Attences after death	Certification:	3 Suicide 6 Could 4 Homicide determ	singd 289. Place	e of Injury - At h ding, etc. (Specil		eet, factory,	office			28f. Location (S City or Tox		Vumber or Rura	al Route Number,
	To the Hospital of Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical (ng Physician: To th Exeminer: On the and ma										
	To t To t	Σ	29b. Signalure and title of certifie	L Pero	mal P	hy Ciri	29c. 1	License	number (00	4359		Terne	Day, Year)
H-	4		30. Name and address of person Robert Brull,					ore					/ /	1, 000
	Sta Registr		31. Date filed (Month, Car Year	7 2005 32.	Registrar's Signa	ature	peli	CLB	WII,	עוני	21,72			

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			1 - For State Registrar		laryland / Dep <i>Ce</i>	artment ertificate			ınd Me	ntal Hy	/giene		5	20305
п	Dhomisi		1. Decedent's Name (First, Middle	e, Last)					2	2. Date of D	eath Da			3. Time of Death
	Physici /Medi		HENRY SCH	UM ER						MAY	30	200	ear	2110 P M
	Examir		4a. Facility Name (If not institution	, give street and number,)	4b. City, 1	Town, or L	ocation of	f Death		4c.	. County ol	Death	
			HOWARD TOUR	MY GENERAL	HOSFITAL		OLVI	MBIA	-			How	ARI	2
	Funeral		5. Social Security Number		ge (In yrs. last birthda)		1 Year Days	If Under 2 Hours	Min.	Date of Bi	irth	9	. Birthp	nlace (State or Foreign
	Director		219-42-6220	1⊠M 2□F	91 Yrs.	Monais	Duys	110013	A	ugust	5,	1913	Nev	York
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I									
	sho	5				.ocation							1	0d. Inside City Limits
	Ne M	Directo	Maryland Howard	i	Columbia									1 Yes 2 No
	with th	ä	10e. Street and Number			10f. Zip					10g. Cit	izen of Wha	at Cour	ntry?
	s 23e	rai	7110 Minstrel Wa	-		2104					U.S.			
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	Was Decede If Yes, speci	ent of His fy Cuban	panic Orig , Mexican,	in? (Speci Puerto Ri	fy Yes or No can, etc.)	0-	14. Race - Black,		
36	s aft	by F	1 ☐ Never Married 2 ☐ Marri 3 🖫 Widowed 4 ☐ Divorced	ied 1 Tes 2 13 If Yes, Give Year or Dates:	:No	1 ☐ Yes 2	⊠ No	Specify:				Specify:	Whi	
21215-0036	72 hours after death with the Maryland neturel', or items 23e or 28e-f show illeal Examinat must be notified at	be	15. Decedent		162 Dec	adaaMa Maya	0				100 10			
75	"ne"	Completed	(Specify only highes		16a. Dec	edent's Usual e kind of work DO NOT use	done du	ion iring most	of working			ind of Busin Lal Se		
12	withi ene. than	Ę,	Elementary/Secondary (0-12)	College (1-4or	5+)	stant						ervice		TLY
	filled Hygir ther	Ö	17. Father's Name (First, Middle,	·					r's Name /	First, Middle			28	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents: If item 27 is marked other than "neturel", or items 23e or 28e-f show amounted to the treumetic event, the Mardical Experiment must be notified at once.	Be									, maideri	Sumane)		
2	hould d Me mark netic	2	David Paul Schun 19a. Informant's Name/Relationsh		10h Mai	in - Address			Fosb		0.1	- T 0		0.11
Ma	d 2 s th an 7 is u					ing Address							ite, Zip	Code)
	1 and Healt em 2 ther		Dennis Schumer / 20a. Method of Disposition	Son	20b. Place of Disp	Bunny								
Baltimore,	S = 10 S		1 ☐ Burial 2 🛣 Cremation		cemetery, cre	matory or oth	ner place)	1	May 3	ľ,		cation - Cit		
ţ	timer in the result of the res		'4 Donation 5 Other (Sp		Mt. Comfo			_	200		Alex	kandri	ia,	Virginia
Bal	permil Depar Impor any ir		21. Signature of Funeral Service I	_icensee		2. Name and				-			-	-
	0.01 = 4 O		The free									on, I).C.	20016
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each I	ine.	TRATI			ardiac or r		arrest,			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				107	~ / • /				DAYS
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):	777			<u> </u>					
	and tran	cam	that initiated events resulting in death) Last	0.	a consequence of):									MANS
8760,	ate be executed hysicien and the burial-transit	E												YEARS
87	cate l	dicai		d. DEME	101114								-	
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	⊒Ectopic pre ⊒ Other (spe					2	23d. Date o		ry Day Year
Δ.	signed b		Part II. Other significant condition	ns contributing to death b	out not resulting in the	ınderlying ca	use given	in Part I.			tobacco u Yes 2[te to th	e cause of death?
Ö	w require been si should l	ete						-						
I Records,	sicien: The law certificate has b irector, page 2 s	Completed by								24a. Was auto perfo 1 Yes		24b. Wer prior deat 1	to con	osy findings available inpletion of cause of
of Vital	Physicien: this certific ral director,	Be (25. Was case referred to medical examiner?				2	26. Place	of Death (C	Check only o	one)			
Ţ	hysic his ce I dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatio	ent 2 ☐ ER/Outpatie	nt 3 DOA	Other:	4 🗌 Nurs	sing Home	5 🗌 Resi	dence 6	6 □Other (Specify)
0	ng Pl		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time (of 28	c. Injury a Work?	ıt	280	l. Describe	how injury	y occurred		
<u>Si</u>	vttendi. death. ctor: A y the fu	ati	2 Accident investig	ation		М	1 ☐ Ye	s 2 🗆 N	0					
Division	or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of In	ury - At home, larm, si c. (Specify)	reet, lactory,	office		28f	. Location (. City or To	Street and wn, State	d Number o	r Rural	Route Number,
	rs aft	Cer		3.										
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best Examiner: On the basis o and manner st	t examination and/or it	th occurred at evestigation, i	the time, n my opin	, date and nion, death	piace, and occurred	due to the at the time,	cause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c.	License n	number		T	29d. Date	e signed (M	lonth, E	Day, Year)
	10		1 thense	dean_ n	7 W		040	892			MA	1 30	7 "	2005
	10		30. Name and address of person v				- 1 ~	- (-			. 1111			
			FRANCIS CHUIC			PATUXE	TOT	PA	MKW	AV	100	DAIR	Α	MN 2044
	Sta	te	31. Date filed (Month, Day, Year)				- 1- 1		- 1,000		(00	- 10101	/)	7.15- 2144
2 4	Registr		JUN 03	2005 February	ar's Signature	ever								

			For State Registrar	State of Mary	rland / Depa		ealth and M	lental Hy	•	gible.	2220
			Decedent's Name (First, Middle, La	st)				2. Date of De.	ath		3. Time of Death
	Physic			Walter SI	MON			Month May 3	Day 1. 2005	Year	9:45 A M
	/Medi Examir		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or I	ocation of Death	may 3		nty of Death	
			3144 Gracefield	Road #407		Silver	Spring		Mor	ntgome	2737
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Bir	th		place (State or Foreignitry)
	Director		100-26-2145	M 2□F	72 Yrs.	Months Days	Hours Min.	(Month, Da May 11			York
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County	10	City Town						
	aryla shov	٦			c. City, Town or Lo						10d. Inside City Limits
	Ba-1	ecto	, ,	omer y	2110	er Spring					1 ☐ Yes 2 💢 No
	with t	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	intry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Medical Examiner must be rodified at	Completed by Funeral Director	3144 Gracefield		-15-11-0 Jan	20904			United		
	Hem Hem	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. H	ace - Amer lack, White	
36	I', or	by F	3 Widowed 4 Divorced	tX Yes 2 No If Yes, Give Year or Dates: Ko		1 ☐ Yes 2大 No	Specify:		Spe	cify: wh	nite
21215-0036	tura sate	edl	15. Decedent's E			dent's Usual Occupat	rion		16b. Kind of	Business/li	odustov
15	n "n	plet	(Specify only highest gr	ade completed)	(Give	kind of work done du DO NOT use retired)	iring most of worki	ng	100, King 0,	Duameaan	loustry
212	with liene r tha	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Elect	rical Eng	ineer/Att	ornev	Cont	ract	Гата
Ö	i Hyg other	Be C	17. Father's Name (First, Middle, Last		HILCCL		18. Mother's Name				Law
a	lenta lenta rked rked	To B	David Simon				Bess Sch	nulkin			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show of other traumatic event, the Wedical Examinatings to contact the rectified at	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rura	l Route Numbe	er, City or Tow	m, State, Zi	p Code)
	alth a 27 le		Warren Simon, Son		3207	Cherry Mil	ll Drive,	Adelpl	ni. MD	2078	33
ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury og other tra once.		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of		Date	20c. Locatio	n - City or T	own, State
Baltimore,	and and and and and and and and and and		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci			natory or other place, tan Cremat		11/05	Alexar	dria	77 A
₫	permit. Pa Departmer Important any injury once.		21. Signature of Fuseral Service Lice			2. Name and Address		717 05	ALCAGE	idi ia,	, VA
Ba	Depar Impor		1 The state of the	/ 	T	orchinsky	Hebrew H				
	Physician /Medical Examiner pura sician and pura liturali-Itansii	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lymphoma Due to (or as a co	ory Failu ensequence of):	•					Approximate Interval Between Onset and Death
.O. Box 68760,	ne death certificate the attending phy: thed for use as the	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a co	regnancy]Fetal death 3	Dectopic pregnancy				Date of delive	rery Day Year
۳.	that the	V Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	obacco use co	intribute to	the cause of death?
ds	uires tha signed Id be det	d by	Weight Loss					101	res 2□No	3 ☐ Pro	bably 4X0Unknown
ö	w requ	ete						04- 116			
Records,	sician: The law certificate has b irector, page 2 s	Completed	_Chronic Sinusiti	S						prior to co death?	opsy findings available ompletion of cause of
a			25 Man again referred to madical						2X No	1 🗆 Yes	2□ No
₹	sicia	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death				
of Vital	Phy this ral d	- T	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatier	" OLI DON	4 🗀 14 di Sirig 110	me 5 3 Resid 28d. Describe t			(fy)
Division	ttanding death. stor: After the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Ye	ear) Injury	Work? M 1 □ Yo	? es 2 □ No				al Route Number,
Ö	s after al Direct	Certif	4 ☐ Homicide determined	building, etc. (S	Specify)	est, ractory, office		City or Tox	vn, State)	noer or Aur	ai noble Noniber,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 1 ★ Certifying Place 2 ★ Medical Exertifying Place 2 ★ Medical	nysicien: To the best of m miner: On the basis of exa and manner stated.	y knowledge, deat amination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurr	and due to the ed at the time,	cause(s) and date and place	manner as s	stated. to the cause(s)
	To t To tl	Ž	29b. Signature and title of certifier	151	/	29c. License			29d. Date sign		
	1		> / Sule	MA De	01	D 219	24		June J	, 200)5
(2+1		30. Name and address of person who	completed cause of death	(Itel 23) (Type,	Print)					
ı,			Herbert S.B. Bar	af, M.D., 27	30 Unive	rsity Blvo	d., W. #3	310. Who	eaton.	MD 2	20902
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's		age)					

DHMH 17 Rev 1/2001

		4	For State Registrar	State of M	laryland / Depa	artment of Hertificate of C		Re	g. No UU	20307
			1. Decedent's Name (First, Middle,	Last)				Date of Death Month	n Day Year	3. Time of Death
	Physicia /Medic		EVELYN	М.	SULLI	VAN		MAY 31		9:48 A M
	Examin		4a. Facility Name (If not institution,	give street and number,)	4b. City, Town, or I	Location of Death		4c. County of De	ath
			9200 ETHAN COU	RT		LAURE				GEORGE'S
	Funeral Director		022-10-2311	6. Sex 1 □ M 2 X F	ge (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, June 23	Year) 9. 8 1917 Ma	irthplace (State or Foreign Country) ISSachusetts
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	sho	2		derick	Mt. Ai	сy				1 ☐ Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What	Country?
	with Ber		4204 Rolling A	cres Drive			.771		United	States
	eath	era	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-		nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show mimorient: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumatic event, its Modical Examinat must be redilled at ances.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces ed 1 □Yes 2 ☑ If Yes, Give Year or Dates:	No	,	Specify:	Hican, etc.)	Black, Wi	White
21215-0036	2 hou	ted	15. Decedent	's Education	16a. Dece	dent's Usual Occupa	tion	ina	16b. Kind of Busines	ss/Industry
75	n nin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	life.	kind of work done do DO NOT use retired)	uning most of work	my		
25	d with giene	E O	12	0		memaker			Own Home	}
Þ	othe vent,	Be C	17. Father's Name (First, Middle, I	Last)			18. Mother's Name			
Maryland	thould by and Menta	ToE	William H. 19a. Informant's Name/Relationsh	Rothfuchs hip (Type, Print)	19b. Maili	ng Address (Street a	Nettie		Smilie City or Town, State	, Zip Code)
Z	id 2 s ith an 27 is treu		Charles W. Sul			B Prestwic				20777
ē,	Heal Heal tem	. 1	20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place		Date	20c. Location - City	or Town, State
D 0	ages ont of t: F i	1	1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp		A I	litan Crem		/05	Alexandr	ia, Va.
Baltimore,	artme artme orten injury		21. Signature of Funeral Service I			2 Name and Address	s of Facility	-		,
Ba	Deprimbe impe		Murief &	N. Boyl	ils /	Muriel H.	Barber	Funeral	Home ville, Md.	20882
			23a Part1. Enter the disease, or	complications that cause	ed the death. Do not en	iter the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.		. ,	6		Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	a. Due to force	Trutter	mins 1	HEALTE			TEANS
	Examiner			Due to (or a	s a consequence of):					
		-	Sequentially list conditions,	b. Due to (or a	is a consequence of):					
	ted nsit	ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
_	be executed iclan and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a consequence of):					
8760,	ate be executed nysiclan and he burial-transit	ical E								
687	ate he	edic		0.						
	The law requires that the death certitics are has been signed by the attending plage 2 should be detached for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of	delivery
Вох	atten for u	Physician/M	in the past 12 months?			□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
o.	by the detached	iysi	1 □ Yes 2 ॲNo 9 □ Unknown	9□ Unknown						
<u>α</u>	that led b		Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause give	an in Part I.	23e. Did tob	oacco use contribute	to the cause of death?
ds	uires sign ld be	d by	CORONA	my moren	DESEASE			1 □ Ye	es 2.122√No 3.□	Probably 4 Unknown
Records,	v require been si should l	pieted		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				24a. Wasa	n 24b. Were	autopsy findings available to completion of cause of
Re	has ge 2	ошо						autops	ned? _ death	?
<u>a</u>		O	Of Manager and to modice				OS Place of Dogs	1 ☐ Yes 2 th (Check only on	2 🗖 🕠 1 🗆 Y	es 2ENo
Vital	sicier	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	itient 2 ☐ ER/Outpatie	ont 30 DOA Othe	200	ome 5 Reside	Control of the Contro	pecity) Daughter
o	Phys r this ral di	H	27. Manner of Death	28a. Date of Ir	njury 28b. Time				ow injury occurred	Residence
	ding F h. After tuner	tion	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	ng (Month, E	Da <i>y Year)</i> Injury		(? Yes 2 □ No			RESIDENCIA
Division	after death. Director: A	Certification	3 Suicide 6 Could	not be 28e. Place of I	Injury - At home, farm, s	treet, factory, office				Rural Route Number,
Θ	lor At after of Direct	erti	4 Homicide	building,	etc. (Specify)			City or Town	n, State)	
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the tuneral director.	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination and/or i	ath occurred at the time nvestigation, in my of	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
	thin thin the mple	Med	29b. Signature and title of certifie			29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)
	T × Z		& En 1	1.1,	_	02	5947	1	npy 31,	2005
7	to	3	00 11-00	fun	i doub (Itom 22a) /T					
	•		30. Name and address of person	completed cause o	4765 THE	Ohups	Corren	10/15	Mn)10	2 0
	CA	ate	31. Date filed (Month, Day, Year)	320 Regi	strar's Signature	- 11 V - C)	WILL!		- 7 ~ 7	
	Regist		JUN 02	2005 Ke	54- The strar's Signature	eve				
				7-0-0-						

			. For	State of	Maryland	d / Depa	artment of H	lealth and	d Mental Hy	/giene	
			- State Registrar			Cei	rtificate of	Death		Reg. No.	20308
П	Physicia	an	Decedent's Name (First, Middle						2. Date of D	Day Year	3. Time of Death
	/Medic				inhard	lt					7:50 A M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o		eath	4c. County of Dea	
			Frederick Men 5. Social Security Number		1tal Age (In yrs. Ia	st birthday)	Freder		Hrs. 8. Date of Bi	Freder	
М	Funeral Director		119-16-7630	18 M 2□F	80	Yrs.	Months Days	Hours N	Ain (Month, D		thplace (State or Foreign ountry) ermany
	ס		Usual Residence of Decedent		1						1
	arylar ehow	-	10a. State 10b. County Maryland Freder			.Town or Lo erick	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne M	ecto	10e. Street and Number				404 75- Codo			10g. Citizen of What C	
	with t	Ö	6865 Snowberry	Court			10f. Zip Code 217	03		U.S.A.	outiny?
	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23e or 28e-1 ehow ent. It's Medical Exertimet has notified at	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S	6. 13.	Was Decedent of F	lispanic Origin	? (Specify Yes or N		
9	or Iter		1 Never Married 2 Mar	ried 1 Yes 2			If Yes, specify Cub	an, Mexican, Pi Specify:	uerto Rican, etc.)	Black, Whi	
93	ref, c	Completed by	3 Widowed 4 □ Divorced	Year or Date	es:		1 ☐ Yes 2 🔀 No	эрвспу.		Specify:	white
5	"netu	ete		it's Education st grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Business	/Industry
2	withir	dmo	Elementary/Secondary (0-12)	College (1-4	for 5+)		gineer	u)		Water puri	fication
g 0	filed Hygid Sther ent.	ပိ	17. Father's Name (First, Middle,	· · · · · · · · · · · · · · · · · · ·			STITECT	18. Mother's	Name (First, Middle	a. Maiden Sumame)	
Maryland 21215-0036	0 m 0 ×	To Be	Jofeph Stei	nhardt				Anna	Bart1		
ary	es 1 and 2 should b of Health and Ments fitem 27 is marked r other treumetic e		19a. Informant's Name/Relations							per, City or Town, State,	
	and 2 ealth a n 27 is		James Steinhar	it - Son				y, Fred	lerick, Ma		
altimore,	ges 1 lof He lf iter or oth		20a. Method of Disposition 1 KBurial 2 Cremation	3 □Removal from S	ate O	ace of Dispo metery, crei	osition (Name of matory or other pla of Grace	сө)	Date	20c. Location - City or	
Ē	tment tent:		*4 □Donation 5 □ Other (5	Specify)		etery		6/3	3/2005		Pennsylvania
Ba	permit. Pages Department of I Importent: If ite eny injury or of		21. Signature of Funeral Service	Licensee	110		2. Name and Addre			Funeral Homederick, Man	eyland 21702
			23a. Part1. Enter the disease, o	r complications that ca	used the death						Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	_		Failure				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a HCM -	r as a consequ		acture				1-2 Days
į.	Examiner		Conventially list and disease	b							
	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		r as a consequ	ence of):					
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to (c	r as a consequ	ience of):					
8760,	ficate be executed physician and is the burial-transit	alE		300.00	. 20 2 00110040						
687	icate phys s the	edical		d							
	eath certific attending p I for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			76			23d. Date of de	livery
Box	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna	th 2 ☐ Fetal nt at time of de		∃Ectopic pregnanc ∃ Other (s <i>pecify</i>) _	у		Month	Day Year
Ö.	that the de ed by the a detached t	hys	9 Unknown	9□ Unknov	vn						
S, P	es the	by F	Part II. Dther significant conditi	ons contributing to dea	ith but not resu	Ilting in the u	inderlying cause gr	ven in Part I.		tobacco use contribute t	
ord	v requir been si should	ted	Sepsis	A		-			- 1	Yes 2.⊡A¶o 3.⊡P	robably 4 □Unknown
Vital Records,	e law l has b	Completed	Coronary	Ar Lery D	riterie				— 24a. Wa:	s an 24b. Were a prior to death?	utopsy findings available completion of cause of
E E	: The licate ha		Metabol'		osis				1 ☐ Yes		s 2□ No
<u>====</u>	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/		Ottoo Otto	200	Death (Check only		
		T. To	1 Yes 2 No 27. Many of Death	28a. Date of	Injury	28b. Time o	f 28c. Inju	ry at		idence 6 Other (Spenior occurred)	ecity)
Division of	Attending Ph er death. ector: After th by the funeral	atlor	1 Natural 5 Pendi 2 Accident invest	ng (<i>M</i> on <i>th</i> , igation	, Day Year)	Injury	Wo	rk?]Yes 2 □ No			
Visi	l or Attendated after death Director:	iffice	3 Suicide 6 □Could	nined 286. Place C	of Injury - At ho g, etc. (Specify	me, farm, sti	reet, factory, office			(Street and Number or Rown, State)	ural Route Number.
	tel or rs afte el Dir	Certification:		Julian	g, 0.0. (<i>Opoony</i>	, 					
	d hour	edical	(Check only 2 Medical	Examiner: On the bas	sis of examinat					cause(s) and manner a , date and place, and du	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Med	one) 29b. Signature and title of certific	and manne	er stated.		29c. Licen			29d. Date signed (Mon	
1	T S S		A	MMX	pro y)		4767	a	May 31,2	-
,	X		30. Name and address of person	who completed cause	of death (Item	23a) (Tvne		1707	,	, , -	
*	13		Francis G. Gri					, Fue.	lenuk,	MD 2170	3
	Sta	ite	31. Date filed (Month, Day, Year	2005 32. 6	gistrar's Signat	ture	L+ #103		-		
	Regist	rar	JUN 0	3 2005		or A	to solve and				

			Please Type or Print in Black Indelible Ink. Ensure All	•	
			State of Maryland / Department of Health and Me	ental Hygien	ie
			1 - State Registrar Certificate of Death	Reg. N	@1115 2030g
	Discontate		Decedent's Name (First, Middle, Last)	2. Date of Death Month D	Day Year 3. Time of Death
	Physicia /Medic		Virginia Sherwood	5	27 / 25 Z150pm
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death
			(Dastal Hospice at the Lake Salis bury		Wicomica
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs/ 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		217-32-5472	septia4	1935 Maryland
	pu ,				
5	anyla shov	Ļ			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
3	Ba-f	cto	MD Dorchester Cambridge		TILET E Z NO
0	ith th	吉	10e. Street and Number	10g. C	Citizen of What Country?
X	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f show he Medical Examinar must be notified at	Funeral Director	611 Douglas Street 21613		USA
0	tems fr	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Ri	rfy Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	or l	by Fi	1 □ Never Married 2 [12] Married 1 □ Yes 2 [12] No 1 □ Yes 2 [12] No Specify:		
8	ural'	Q D	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Black
77	nat	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/Industry
5	withir ne. ihan	E D	Elementary/Secondary (0-12) College (1-4or 5+)	Ca	Taul au
2	e filed within al Hygiene. I other than ' vent, Lie We		Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (Since Middle Maid	Wing FOCTORY
ä	be f lall f od of	Be		rirst, Middle, Malde	an sumamey
<u> </u>	2 should be and Mental is marked c	ပ္	Joshua Thomas Magg	ie Tl	DOMPSON
ā	12 st h and 7 is n rraun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Yural I	~	or Town, State, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depenment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.		Herbert Sherwood 611-Douglas Street 20a. Method of Disposition 20b. Place of Disposition (Named) Dat	Cambri	19E, MD: 21613
o i	Pages 1 nent of H int: If ite		20a. Method of Disposition 20b. Place of Disposition (Name bt cemetery, crematory or other place) 20b. Place of Disposition (Name bt cemetery, crematory or other place)	1 - 2	Location City or Town, State
Ē	nit. Pagestmeni ortant: injury		"4 Donation 5 Dother (Specify) Bucktown Cemetery 6/4	105 Ca	Mbridge, MD.
a	permit Depent Import any in		21. Signature of Funeral Service Licensee 22. Name and Address & Facility 22. Name and Address & Facility HENRY FUNERAL 140		-
ш.	20 E E 9		Jowelle C. Serry Slowoshington S	to Cambr	, da e, MD. 2/6/3
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a TVLM on ATTY FOR BOUS M-		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):		
	Examiner		Sequentially list and distance		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	be executed icien and burial-transit	Examiner	that initiated eventsc		
o,	en ar rial-t		resulting in death) Last Due to (or as a consequence of):		
760,	6 × 6	cal	d		
68	The law requires that the death certificate bate has been signed by the attending physic page 2 should be detached for use as the bage.	Physician/Med			
Box	h cer andir use	N/	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	deat e atfe	ICIa	If the past 12 moreons? 1 □ Yes 2 □ 10		Month Day Year
P.0	thaf fhe do	hys	9 □ Unknown 9□ Unknown		
	signed d	γP	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Ę	quire n sig uld b	be	AMPOTROPHIC SCLETCOSIS	1 🗌 Yes	2☐No 3☐Probably 4☐Unknown
8	aw requir as been s 2 should	Completed by	THARETES MELLINS	24a. Was an	24b. Were autopsy findings available
Re	The lav	m C		autopsy performed?	prior to completion of cause of death?
o			25. Was case referred to medical 26. Place of Death (1 Yes 2	¶o 1 ☐ Yes 2 ☐ No
Division of Vital Records,		o Be	examiner?		
of	Phys r this aral di	. To	patient 2 El Podipatient 3 BOA 4 Nulsing Home	e 5 Hesidence	6 ☐ Other (Specify)
on	iding Phy th. : After this	tlor	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No		ary costanou
2	of or Attendial after death. Director: A d in by the fu	Certification;	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office 28	If Location (Street)	and Number or Rural Route Number.
Š	after Dire	erti	4 Homicide determined building, etc. (Specify)	City or Town, Sta	
	Hospitel 14 hours a Funeral I		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the course	(a) and manager as stated
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	nd place, and due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier 29c. License number	29d. E	Date signed (Month, Day, Year)
	r s r ö) James To France 7714756	1	128/06
			20 None of address of a separate of a separa		Wind Total
			30. Name & address of person who completed cause of death (Item 23a) (Type, Print)	NOTO =	128/05 15742 NOSTKE
	Sta	to.	31. Date filed (Month, Day, Year) 2 222 32. Restrar's Signature	(1) 21	002
	Sta Registr		JUN 0 2 2005		

DHMH 17 Rev 1/2001

Physici /Medic		 Decedent's Name (First, Middle, Last) 			2	2. Date of Death	ne No. 2005	3. Time of Death
		JoAnn Taylor				JUNE 8, 2	Day Year 2005	1:50 A
Examir	_	a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or	Location of Death		4c. County of Death	
		CALVERT MEMORIAL HOSPITAI		PRINCE F	1/11 1 0111		CALVERT C	
Funeral Director		5. Social Security Number 214-76-4239 Usual Residence of Decedent	7. Age (In yrs. last birthday) 53 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye Aug. 4,	9. Birth Cou 1951 West	place (State or Fore ntry) Virginia
show		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Lim
ms 23a or 28a-f show	Funeral Director	MD Calvert County	Dunkirk					1 ☐ Yes 2 🟋
or 2	Dire	10e. Street and Number		10f. Zip Code			Citizen of What Cou	ntry?
ns 23.	eral	3502 King Drive 11. Marital Status 12. Was Decei	dent Ever in U.S. 13.	20754	spanic Origin? (Spec		U.S.A.	can Indian
it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Items 23a or 28a-f shov or other traumatic avent, I'm Medical Exarting in it must be rediffed at	þ	1 XNever Married 2 Married 1 Yes 3 Widowed 4 Divorced Armed For 1 Yes, Giving Year or Da	ces? 2 <mark>X</mark> No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 X No		ican, etc.)	Black, White,	etc.
natura Jical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	tion	168	o. Kind of Business/In	dustry
han "	mple	Elementary/Secondary (0-12) College (1-	4or 5+) life.	DO NOT use retired)		'	27./4	
Hygie ther t nt, I		N/A 17. Father's Name (First, Middle, Last)	Ne	ver Worked	18. Mother's Name (First Middle Mai	N/A	
ind Mental I s marked of umatic ave	To Be	Robert Taylor			Mable Ge		uen Sumame)	
a mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street a	nd Number or Rural	Route Number, C	ity or Town, State, Zip	Code)
n 27 is n 27 is er tra		Barbara Chambers (Siste	r) 4105	Oakdale I	ane. Port	Republi	c, Marylar	nd 20676
of He If itam or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Dispo	osition (Name of matory or other place	Da	te 200	. Location · City or To	own, State
tant: tant: jury c		' 4 ☐ Donation 5 ☐ Other (Specify)	Resurrect	tion Cemet	ery 20	05° CI	inton, Mar	
Department of Health Important: If itam 27 any injury or other troones.		21. Signature of Enhance Service Licenses MICHAEL W. Lee	8.	2. Name and Address 125 Southe	s of Facility Lee ern Maryla	nd Blvd.	Home Calve , Owings,	Marylan 2073
Medical and the principle of the princip	dical Examiner	resulting in death) Due to (of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of): or as a consequence of): or as a consequence of):	cerebral	palsy			
	0 1	23b. Was decedent pregnant	come of pregnancy	□Ectopic pregnancy			23d. Date of delive	ary Day Year
the attending ned for use as	ysicia	in the past 12 months? 1 Yes 2 No 4 Pregna 9 Unknown 9 Unknown	int at time of death 5	Other (specify)				
gned by the attending be detached for use at	d by Physici	1 ☐ Yes 2 ☐ No 4 ☐ Pregna	unt at time of death 5 [wn	Other (specify)	n in Part I.	23e. Did tobace	co use contribute to to	
ate has been signed by the attending page 2 should be detached for use as	Completed by Physicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregns 9 ☐ Unknown 9 ☐ Unkno	unt at time of death 5 [wn	Other (specify)	n in Part I.		2 No 3 Prob	pably 4 Unknown psy findings availampletion of cause
ate has been signed by the attending page 2 should be detached for use as	Be Completed by Physician/M	1 Yes 2 No 9 Unknown 9 Unk	unt at time of death 5 [wn	☐ Other (specify)	26. Place of Death (1 Yes 24a. Was an autopsy performed 1 Yes 2 Check only one)	2 No 3 Prot	posty findings availampletion of cause
n. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de 25. Was case referred to medical examiner? Yes 2 No 1 In In In In In In In In In In In In In	ant at time of death 5 [which will be seen the seed of the seed o	other (specify) underlying cause gives nt 3 DOA Other 28c. Injury Work	26. Place of Death (r. 4 ☐ Nursing Home at 28	1 Yes 24a. Was an autopsy performed 1 Yes 2 Check only one)	2 No 3 Prot	pably 4 Inkno
n. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de 25. Was case referred to medical examiner? Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Could not be	ant at time of death 5 [which will be seen the seed of the seed o	other (specify) Int 3 DOA of 28c. Injury Work' M 1 Y	26. Place of Death (r. 4 □ Nursing Home at 28 r. es 2 □ No	24a. Was an autopsy performac 1 Ayes 2 Check only one) 9 5 Residence d. Describe how i	2 No 3 Prot 24b. Were autoprior to codeath? No 19 Yes a 6 Other (Special njury occurred	poppy findings availampletion of cause 2 No
n. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	Certification; To Be	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de 25. Was case referred to medical examiner? Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Could not be	ant at time of death so with the understanding in t	other (specify) Int 3 DOA Other Ot	26. Place of Death (r. 4 \(\triangle \triang	24a. Was an autopsy performed 124 yes 2 Check only one) 5 Residence d. Describe how i	2 No 3 Prot 24b. Were autoprior to co death? No 19 Yes 4 6 Other (Special njury occurred t and Number or Rura tate)	pably 4 Inkno posy findings availa mpletion of cause 2 No y) Al Route Number, tated.
r this certificate has been signed by the attending ral director, page 2 should be delached for use a	To Be	25. Was case referred to medical examiner? Yes 2 No 9 Unknown 26. Was case referred to medical examiner? Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Place building 29a. Certifier (Check only 2 Medical Examiner: On the ba	ant at time of death so with the understanding in t	other (specify) Int 3 DOA Other Ot	26. Place of Death (r. 4 \sum Nursing Home at 28 r. es 2 \sum No 28 a, date and place, an inion, death occurred number	24a. Was an autopsy performed 1 Yes 2 Check only one) 9 5 Residence d. Describe how in f. Location (Stree City or Town, S d due to the cause at the time, date 29d.	2 No 3 Prot 24b. Were autoprior to co death? No 19 Yes 4 6 Other (Special njury occurred t and Number or Rura tate)	popphy findings availampletion of cause 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No

	•		For		ryland / Dep			fental Hyg	iene)	15 20211
			= State Registra AMEND#7perFH6/3		o Ce	rtificate of	Death		g. No.	0 60011
	Physicia		Decedent's Name (First, Middle, Last,					2. Date of Deat Month	2 ^{Day} 2005	3. Time of Death
	/Medic	al -	Gholamali '	Taefi		Ab City Town o	r Location of Death	June	4c. County o	
	Examin	er	Manor Care - Beth			Bethesd			Montgon	
	Funeral		5, Social Security Number 6. Se	x 7. Age	(In yrs. last birthday,		If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
	Director		240-31-4899	Ž M 2□F	89 <u>97</u> _{Yrs.}	Months Days	Hours Min.	(Month, Day, Feb. 12		Iran
	p ,	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	shov	5				ocation				1X Yes 2 □ No
	28a-f	ect	MD Montgomes 10e. Street and Number	ТУ	Bethesda	10f. Zip Code		1	0g. Citizen of W	hat Country?
	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f show the Moulcal Examiner must be notified at		5101 River Road			20816			•	,
	ms 2;	era	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		- American Indian,
စ္	or Ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 N If Yes, Give	lo	1 ☐ Yes 2X No	Specify:	nicari, etc.		, White, etc.
21215-0036	ural',	db	3 Widowed 4 Divorced	Year or Dates:						White
<u>5</u>	"net	ete	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of work		16b. Kind of Bus ranian	iness/Industry
7	withir ene. than	дшо	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Presiden		C	il Comp	anv
р О	filed Hygi othar ant.	ပိ	17. Father's Name (First, Middle, Last)		VICE	TTESTUEII	18. Mother's Name			
Maryland	is 1 and 2 should be filed within 7 of Health and Mental Hygiene. itam 27 is marked othar than "r other traumatic evant. It a Mod	O B	Hassan Taefi				Soghra E	manoff		
ary	s ma		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Number	, City or Town, S	State, Zip Code)
Σ,	and 2 ealth m 27		Mitra Khayami / Da	aughter			Rd Bethes			
ore	Fita ita		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ I	Removal from State		osition (Name of ornatory or other pla	ce)			City or Town, State
Ë	tment tent:		*4 □Donation 5 □ Other (Specify,)	Mt. Comf			and the same of th		ia Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene bipportent: If item 27 Is marked other than "netural", or Items 23e or 28a-1 show Importent: If item 27 Is marked other than "netural", or Items 23e or 28a-1 show Importent in the month of the		21. Signature of Funeral Service Licens	Muny			ss of Facility Jos nsin Ave.	•		
			23a. Part1. Enter the disease, or comp shock, or heart failure. I st only of	lications that caused one cause on each lin	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Myocar	dial Infa	rction				Onset and Death day
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):					
	ZAGIIIIICI	4	Sequentially list conditions,	b. — Due to (or as a	a consequence of):					
	uted insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć,	execting and and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
8760,	death certificate be executed e attending physician and nd for use as the burial-transit			d						
9	ntifica ng ph s as th	Med	IF FEMALE:							
Вох	eath certifica attending pl I for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death 3	□Ectopic pregnanc	y		23d. Date Mon	of delivery th Day Year
0.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (specify) _				
٩.	that the de led by the detached	Ph.	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	pacco use contri	bute to the cause of death?
ds,	Se L60	d by						1 🗆 Ye	s 2 No	3 Probably 4 Unknown
COL	> 10	lete						24a. Was a		ere autopsy findings available
Re	9 L 9	Completed						autops perform	ned? de	rior to completion of cause of eath? □ Yes 2□ No
Vital Records	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Deat			
of V	S S	To E	1 Yes 2 No		nt 2 ER/Outpatie	AIL 3 DOW		ome 5 Reside		
	ter Ter	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Time y Year) Injury	Wo	ryat rk? Yes 2 ⊡No	28d. Describe ho	ow injury occurre	d
Sio	tand leath tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be		ury - At home, farm, s		162 5 140	28f. Location (SI	reet and Numbe	r or Rural Route Number,
Division	in Dir	Certification:	4 Homicide determined	building, etc	c. (Specify)	11001, 120101), 011100		City or Town	n, State)	
	To the Hospital or At within 24 hours after of To tha Funaral Diract completely filled in by	aC		ysician: To the best						
	n 24 t n 24 t ha Fu pletely	edical	(Check only 2 Medical Exam	and manner sta						nd due to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year)
	V		Multot			D005	5694	J	une 2,	2005
			30. Name and address of person whe Alok Mathur MD 400	00 01ney-L	eath (Item 23a) (Type aytonsvil	le Rd. 01:	ney MD 20	832		
	Sta	ite	31. Date filed (Month, Day, Year)							
L	Registi		JUN 03 20	105	ar's Signature					

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			For 1 ≃ State Registrar	State of	Marylan		artment rtificate			ind M	ental Hyg	giene Reg. Nó.	005	20312
			1. Decedent's Name (First, Middle, Last,)			* * * * * *				2. Date of Dea Month	ith Day	Yea	3. Time of Death
	Physici: /Medic		Joseph Patrick Tr	ainor,	Jr.						June (,	2005	1:25 A ^M
	Examin		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City, T	own, or	Location o	f Death		4c.	County of De	eath
			Casey House				Rock			7411==			Montgo	
	Funeral		5. Social Security Number 6. Se	x 7. ØM 2□F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day	(, Year)	9. 8	Birthplace (State or Foreign Country)
	Director		577-36-3676 Usual Residence of Decedent		76						05/21/	1929	Pe	nnsylvania
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Man a-f sh	tor	MD Montgome	ry	Ro	ckvill	e							1 ☐ Yes 2 💢 No
	th the	irec	10e. Street and Number				10f. Zip C	Code				10g. Citi	zen of What	Country?
	th wil	Funeral Director	5213 Brentford Dr	ive			208	352				U.	S.A.	
	r dea	ner	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		 Race - Al Black, W 	merican Indian, hite, etc.
30	s afte , or It	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 If Yes, Give Year or Date			1 □ Yes 2	∑ No	Specify:				Specify: T.	Thite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the than "natural", or items 23s or 28s-f show aft, it is Madical Exaciliner must be notified at		15. Decedent's Edu		es: 195		dent's Usual	Occupa	tion		1	16b Kir	nd of Busine	
Ċ	in 72	Completed	(Specify only highest grad		les 5 . \	(Give	kind of work DO NOT use	done di	urina most	of worki	ng			,
212	with piene.	mo	Elementary/Secondary (0-12)	College (1-4	ior 5+)	Prin	ter					Fed	eral G	overnment
פַ	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural; or Items 23a or 28a-f show svent, I'rs Madical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Sumame)	
<u>a</u>	Ments Ments arked	10	Joseph Trainor						Anna	1 O'M	lalley			
Maryland	2 sho and I s me		19a. Informant's Name/Relationship (T)	ype, Print)		1					l Route Numbe	-		
≥	and ealth m 27 her tr		Connie M. Trainor	, Wife	005 5	_					Rockvil			
o o	Sor of H		20a. Method of Disposition 1 ☐ Burial 2 🗓 Cremation 3 ☐ F	Removal from St		Place of Disponentery, crea							-	or Town, State
<u>=</u>	tant:		' 4 □ Donation 5 □ Other (Specify)		Ft.									, Maryland
Baltimore,	permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If item 27 is marked oth any injury or other treumatic sven once.		21. Signature of Funeral Service Licens	oan l	Duty	10		ckv	ille	Pike		ille		yland 20852
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cau ne cause on eac	used the deal	h. Do not en	ter the mode	of dying	, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Metas	tatic :	Malign	ant Me	e1an	oma					Offset and Death
	/Medical Examiner		resulting in death)	Due to (or	r as a conseq	uence of):								
	Lxammer	L	Sequentially list conditions,	b. — Due to /or	r as a conseq	upper of).								
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or	as a conseq	dence or):								Į.
II.	xecut and al-trar	хап	that initiated events resulting in death) Last	c. Due to (or	r as a conseq	uence of):								
8760	ate be executed thysician and the burial-transit			d										
687	ficate p phy: ss the	edic		0										
Box	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna							2	3d. Date of	delivery
m	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		⊒Ectopic pre ☐ Other (s <i>pe</i>					122	Month	Day Year
o.	at the by th tache	hys	9 Unknown									-		
	The law requires that the de ite has been signed by the a page 2 should be detached I	by F	Part II. Other significant conditions co	ntributing to dea	th but not res	ulting in the u	inderlying ca	use give	n in Part I.				_	to the cause of death?
ord	w requir been si should					***					1 L Y	es 25	MiNo 3∐	Probably 4 Unknown
Records,	has be	ple									24a. Was autop	sy	prior	autopsy findings available o completion of cause of
		Completed									perfor	mea? 2 X No	death	? es 2□ No
Vital	Physicien: The tribic certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Otho	-		(Check only o			
of	Physic this cal dir	2	1 ☐ Yes 2 X No 27. Manner of Death	1 □ Ing		ER/Outpaties 28b. Time o		othe c. Injury	4 140		ne 5 🗌 Resid 28d. Describe h			pecify) Hospice
UC.	Jing After fune	ion	1 X Natural 5 ☐ Pending	(Month,	Day Year)	Injury	M 20	Work	? ′es 2 🔲 !		od. Describe n	iow injur	CCUITEG	
Division of	Attending in death. ector: After by the funer	ficat	3 Suicide 6 Could not be	200. Place 0	f Injury - At h	ome, farm, st								Rural Route Number,
<u>≥</u>	after Dire	Certification:	4 Homicide	building	g, etc. (Specif	(y)	, ,,,				City or Tow	m, State,)	
	To the Hospitet or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the biner: On the bas	is of examina	owledge, deat tion and/or in	h occurred a	it the tim	e, date an inion, dea	d place, a	and due to the ded at the time, d	cause(s) date and	and manner place, and c	as stated. lue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	, , , , , , , , , , , , , , , , , , ,		29c.	License	number			29d. Dat	e signed (Mo	onth Day, Year)
	F 3 F 8		VIMI					NL	112	10	/		2/2	105
	Ų		30. Name and address of person who c	completed cause	of death (Iten	n 23a) (Tvpe	Print)		14	-0		(0/1	
			Charles Harrison,					Road	, Roc	ckvil	lle, Mai	ry1a	nd 208	55
	Sta	ate	31. Date filed (Month, Day, Year)	3 2 Rec	gistrar's Signa	ature	N a							
	Regist	rar	JUN 03 200	10 Elle	gistrar's Signa	S ASSESSED	MEL.							

DHMH 17 Rev 1/2001

05-04010 Lewis Taylor, Gary RJD

)		-	- State Amend Item 1	State of Marylar &Unpend Item	23a&27 Ce	artment per m rtificate	e G8	ealth and N 45 7-25- Death	Aental Hy 05 tas	giene Reg. No	005	20313
	hysicia /Medic		1. Teseden's Name (First Middle, La. Cary Louis Ta	ylor.					2. Date of De June 1		O5 Year	3. Time of Death 1030 A. M
	Examin		4a. Facility Name (If not institution, giv Western Maryland		Inst.	4b. City, 7 Cresa		Location of Death			ounty of Dea	
Di	ineral rector		5. Social Security Number 6. S 577 90 5819	ex 7. Age (In yrs.	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/26	th by. Year) 6 3	9. Bi	rthplace (State or Foreign Sountry) ashington, I
laryland	show at at	5	Usual Residence of Decedent 10a. State 10b. County DC	10c. C	ity, Town or Le	ocation ingto	n					10d. Inside City Limits
with the M	a or 28a-f	Director	10e. Street and Number 1646 Montello	Ave NE		10f. Zip		2		10g. Citize	on of What C	country?
aryland 21215-0036 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene.	al', or itams 23a or 28a-f shov Exeminer must be mulified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			ent of His	spanic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		I. Race - Am Black, Wh Specify: B	
Maryland 21215-0036 at 2 should be filed within 72 hours att th and Mental Hygiene.	than "natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2 t h	ducation ide completed) College (1-4 or 5+)	(Give	dent's Usual kind of won DO NOT use NA	l Occupa k done d e retired)	tion uring most of worl	king	16b. Kind	of Business	s/Industry
rland uld be file Aental Hys	rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last, Elijah Thorne					18. Mother's Nam Luella	ne (First, Middle a Dawk:		umame)	
Mary and 2 shor	27 is me ar treuma		19a. Informant's Name/Relationship (Luella Taylor	Type, Print) mother		ng Address R St		nd Number or Ru Wash:	ral Route Numb ington		Town, State, 20002	Zip Code)
Baltimore, Dermit. Pages 1 a	Importent: If item 27 Is marked other any injury or other treumatic event, Ill once		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specif	Removal from State	Place of Dispo cemetery, cre Slenwo	matory or ot	e of her place	6/18	Date 8 / 0 5			r Town, State on, DC
Balti permit. Departm	Importent: If it		21. Signature of Funeral Service Licer	nsee				efal Ho				,DC 20011
Phys	sician		23a. Part1. Enter the tisease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea one cause on each line. Pneumonia	th. Do not en	ter the mode	of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Me	edical miner		resulting in death)	Due to (or as a conse	quence of):							
O, sexecuted	physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse				44				
68760, tificate be ex	O) ed	edical	•	d								
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.	y the attending	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>				23	d. Date of de Month	olivery Day Year
rds, P.	906	þ	Part II, Other significant conditions of	contributing to death but not re	sulting in the L	inderlying ca	ause give	n in Part I.				to the cause of death? Probably 4 Unknown
Vital Records,	certificate has been si rector, page 2 should b	Completed							24a. Was auto perfo	an psy prmed? 2 \(\text{No} \)	24b. Were a prior to death? 12 Ye	uutopsy findings available completion of cause of
of Vita Physicien	O TO	To Be	25. Was case referred to medical examiner? ™©¥res 2 □ No]ER/Outpatie			4 🗆 INDISHING FI	ome 5 ☐ Resi	dence 6		ecify) (scene)
Division of or Attanding Patter death.	After	Certification	27. Manner of Death 1X Natural 5 Pending investigation		28b. Time o Injury	М		at ? ′es 2 □ No	28d. Describe			
DIVIS	rel Director: led in by the	Certifl	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory,	, office		28f. Location (City or To		Number or F	Rural Route Number,
he Hosp n 24 hou	To the Funerel D completely filled in	Medical		nysician: To the best of my kn miner: On the basis of examin and manner stated.								
To the within	Tot	Σ	29b. Signature and title of certifier Pollusel	lah Ali			License C.I				signed (Mon 12, 2	nth, Day, Year) 005
	•		30. Name and address of person who ZABIUUAH	completed cause of death (Ite	m 23a) (Type	Print) 11	L1 Pe	enn Stre	et Bal	Ltimoı	re, Ma	ryland 21202
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	ande						

			1 - For State Registrer	State of Ma	ryland / Depa <i>Ce</i> a	artment of Hertificate of E	ealth and Death		giene Reg. No.	0 0 5	20314
			1. Decedent's Name (First, Middle, Last)				-	2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Lelia Vir	ginia	Tusing			June	Day 1	2005	6:00 a M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea	th	4c. C	ounty of Death	
			6780 Hallowing	Point La	ane	Prince	Freder	rick	C	alvert	
	Funeral		5. Social Security Number 6. Sex	M 2X F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h (Year)	9. Birth	place (State or Foreign intry)
	Director		5/8-05-0648	M ZAIF	90 Yrs.	,			3, 1	914 V	Trginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation					10d. Inside City Limits
	Maryl f sho	ō	MD Calvert		•			_			1 ☐ Yes 2√∑ No
	the 28a-	Funeral Director	MD Calvert 10e. Street and Number			Prince Fr	ederick		10a Citiza	on of What Cou	
	3a or	D	6780 Hallowing Poi	nt Tano			678				,
	death ms 2	era		2. Was Decedent Ev	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban		Specify Yes or No-		SA J. Race - Ameri	can Indian.
9	after or ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No)	_		to Rican, etc.)		Black, White	
03	rei', o	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	ŀ	1 □ Yes 21X No	Specify:		5	opecify: white	te
21215-0036	filed within 72 hours after death with the Maryland Hyglene. uther than "naturel", or items 23e or 28e-f show uther than "naturel", or items 23e or 28e-f show ont, the Medical Exeminer must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupation of work done do	tion uring most of wa	orkina		of Business/Ir	
21	ithin ne. ne.	npi	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired)		9			
2	led v fygle her t nt, m		6		hom	emaker				n home	
anc	I be fi	Be	17. Father's Name (First, Middle, Last)	C	mad mlal o			me (First, Middle,		,	-L
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show my injury or other treumatic event, the Medical Evantinet must be notified at ance.	To	Franklin 19a. Informant's Name/Relationship (Type		prinkle	ng Address (Street a	Lotti		san		step
Ma	ith an treu		Wilda Griffin-Wil			.O. Box 19				10wn, 31a18, 21 512	o Code)
ā,	of Health of Health litem 27 i		20a. Method of Disposition	diari, dau	20b. Place of Dispo	sition (Name of		Date Date		ation - City or T	own, State
Baltimore,	Pages nent of H ant: If ite ury or of		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	1	natory or other place	1	2 2005	Dron	5001	M
Ħ	permit, Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	18_		oln Cemete Name and Address		13-2005	brein	Lwood,	MID
ä	permi Depar impor any ir		William R C	720	R	ausch Fu	neral	Home, F	A	Owings	. MD
	HIER !		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ons that caused to	he death. Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		KE-REC	UPPERT					Onset and Death
	/Medical		resulting in death)		consequence of):	0,0,0,000					40N743
ю	Examiner		Sequentially list conditions, b							_	
	pe tis	ine	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a	donsequanda oi):						
	and and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):				_		
8760,	cate be executed physician and the burial-transit	E E		200 10 (01 83 8	consequence or).					1	
387	icate phys s the	dicai	d								
×	certif ding se as	/Me	IF FEMALE:	3c. If yes, outcome of	f pregnancy				22	d. Date of deliv	
Вох	death atter	clar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23	Month	Day Year
0	The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 🔁 No 9 ☐ Unknown	9□ Unknown							
٦,	es that igned to be det	by P	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
Records,	v require been sig should b	ed t	HYPERTENSION	V, H71	OTH/	01913/)	1 □ Y	es 2	No 3□Prot	oably 4 Unknown
000	law requ as been 2 shoult	plet	BIZ DEFICIE			·		24a. Was a		24b. Were auto	psy findings available
Ä	vicl en : The lav certificate has rector, page 2	Completed						autops perfor		death?	mpletion of cause of
Vital	ysiclen: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or			
of V	Q S	2	1 □ Yes 22 No	ospital: 1 🗌 Inpatient	t 2 ER/Outpatier	t 3 DOA Other	4 Nursing H	Home 5 Reside	ence 6[☐Other (Specif	ý)
n		.io	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work?	?	28d. Describe he	ow injury	occurred	
<u>S</u> :	uttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	00 01 111			es 2 No				
Division	i or Attendater death Director:	Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and i n, State)	Vumber or Rur	al Route Number,
	pltai		29a. Certifier Certifying Phys	ician: To the best of	my knowledge, dogs	a conversed at the time	dote and also	and due to the o		d	A-A
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Exeminone)	er: On the basis of e	examination and/or in	vestigation, in my opi	nion, death occi	urred at the time, d	late and p	ace, and due to	the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	1	-	29c. License	number	2	9d. Date	signed (Month,	Day, Year)
			1/1/1/2/3	mal a	4	720	358		TU	1= 20	2001
	10		30. Na address of person who co	leted cause of dea	ath (Item 23a) (Type,)	0,0	
-	D		130 H~ H-	WEIGE	- CM 5	PRINCE	FREJE	RICK.	m)	- 20	670
	Sta		31. Date filed (Month, Day, Year)	32. Registr	s Signature	books					
	Registr	al	JUN - S	LACOL & JOSE	WENDER JA						

			For State Registrar		State of N	/larylan					d Mental I	lygien	e005	20315
				Com A Adidala La			Ce	rtificate	of De	eath	2. Date of	Reg. N	0.	C. First of Dooth
	Physici	an	1. Decedent's Name			Шb o г					Month	D	ay Year	3. Time of Death
	/Media		Willia: 4a. Facility Name (If		Carl ve street and number		npson	4b. City. 7	Town, or Lo	cation of D	May	27	2005 c. County of Dea	11:30p M
	Examir	ıer			ryland Bl				hian				Anne Ar	
	Funeral		5. Social Security Nu	umber 6.	Sex 7.7		last birthday,		1 Year If	Under 24 Hours	Hrs. 8. Date of	Birth Day, Yea		thplace (State or Foreign ountry)
	Director		335-28-17	794	1 X M 2□ F	81	Yrs.	Months	Days	nours r	April	21,	924 Flo	rida
	p s		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or L	ocatio <i>n</i>						10d. Inside City Limits
	Aaryla f aho	ō	MD	Anne Ar	ımdal		othian							1 ☐ Yes 2 ☑ No
	28a-	rect	10e. Street and Num		under	Т.	Julian	10f. Zip	Code			10g. C	itizen of What C	
	3a or	by Funeral Director	6229 Sout	thern Ma	ryland Bl	vd.			2071	11			U.S.A	
	death	nera	11. Marital Status		12. Was Deceder	nt Ever in U	.S. 13.	Was Decede	ent of Hispa	anic Origin	? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Am Black, Whi	erican Indian,
9	or its	F.	1 Never Marrie		112 Yes 2	□No		1 🗆 Yes 2		Specify:	dono i nodin, oro.		0	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f ahow 'ns Medical Exaini actinative rodified at		3 Widowed		Year or Dates	:1945-	-4/					401	WI	nite
15-	"nat	Completed		15. Decedent's E ify only highest gi	rade completed)		(Give	dent's Usua kind of won DO NOT us	k done durir	ng most of	f working	160.	Kind of Business	Vindustry
212	iene. iene. than	mo	Elementary/Secon	ndary (0-12)	Coilege (1-4d	r 5+)		r of (pract	ic	Hea	ılth car	е
þ	e filec ti Hyg otha vant,	Be C	17. Father's Name (First, Middle, Las					18	. Mother's	Name (First, Mic	dle, Maide	n Sumame)	
/lar	Menta	To	William	Kenne	th Thom	pson				Mil	dred M	inett	e Joh	nson
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "neturel", or items 23a or 28a-f ahow other traumatic event. I've Medical Examinar traumatic event, I've Medical Examinar traumatic event.		19a. Informant's Na	•				•			or Rural Route Nu			
	l and fealth im 27 har tr		Linda C.		n, wife	20h E	6229			nd Bl	vd., Lot	-	MD 20 ocation - City or	711
lor	int of H			Cremation 3	Removal from Sta	. 0	emetery, cre	matory or ot	her place)	1				
Baltimore,	permit. Pa Departmen Important: any injury	-	4 □Donation 21. Signature of Fur	5 Other (Spec	1	Meci		2. Name and			6/01/05	ATE	xandria	, VA
Ba	permit. Pages 1 and 2 Department of Health a important: If item 27 Is any injury or other tre <u>once</u> .		21. Signation of the	/1/		1/2				1	omo II A	/~		D 20726
	TV 85 1		23a. Part 1. Enter th	e disease, o cor	np cations that caus	ed the deat					ome, P.A		ings, M	Approximate
	Physician		Immediate Cause (Final	y one cause on each		2~1	0.0	- (0	لىرى			Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	•	a Due to (or a	as a conseq		0000	21'					Zueek
	Examiner		Sequentially list con	nditions	b									
	pi ji	Examiner	Sequentially list cor if any, leading to im	mediate	Due to (or a	as a conseq	uence of):							
	and I-tran	xam	Cause (Disease or i that initiated events resulting in death) L		c	as a conseq	uence of):							
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ical E		- (,								
687	flicate g phys				Q							-		
Вох	anding use	M/ul	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcon			⊒Ectopic pre	2000001				23d. Date of de	livery
	death	sicia	in the past 12 t		4☐Pregnant	at time of d		Other (spe		-			Month	Day Year
P.0	that the death ned by the atter detached for u	Physician/Med	9 Unknown						-					
	signed I			Cant conditions	contributing to death	Dut not res	•	inderlying ca	iuse given ir	п Рап I.			/	the cause of death?
oro	w require been si should	eted	1001	011130	11- DI3	QUY			-		- 16	-		
Records,	The law cate has b page 2 s	Completed by									_ 24a. V	ras an utopsy erformed?	prior to death?	utopsy findings available completion of cause of
a	ician: Th certificate ector, pag	e Co	25. Was case referr	red to modical						2. Dinon of		s 2 11 K	0 1 ☐ Yes	2 □ No
Vital	iding Physician: th. After this certifica	To Be	examiner?	/	Hospital:	ntient 2	ER/Outpatie	nt 3 🗖 DO	0		Death (Check or ng Home 5	-	6 ☐Other (Spe	c(fy)
of	g Phy er thi	F.:	27. Manner of Death	1	28a. Date of Ir (Month, I		28b. Time o		3c. Injury at Work?				ury occurred	<i>ony,</i>
io	Attending in death. actor: After by the fune	atio	1 Natural 2 ☐ Accident	5 Pending investigation	on	Juy / Jui/	Injury	М		2 □ No				
Divísion	or Atte	tific	3 Suicide 4 Homicide	6 Could not determined	286. Place of	injury - At he etc. (Specif	ome, farm, st	reet, factory,	office		28f. Locatio City or	n (Street a Town, Sta	nd Number or R 'e)	ural Route Number,
	urs af ral D	Sel									<u> </u>			
	the Hospital hin 24 hours a the Funaral I npletely filled	Medical Certification:	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the be miner: On the basis and manner	of examina	wledge, deal tion and/or in	h occurred a vestigation,	at the time, o in my opinio	date and p on, death o	place, and due to occurred at the tir	he cause(ne, date a	s) and manner a: nd place, and due	s stated. e to the cause(s)
	To the Hospital or Attenc within 24 hours after death To the Funaral Diractor: completely filled in by the	Mec	29b. Signature and	title of certifier	and manifer	o,arod.		29c.	License nu	umber		29d. D	ate signed (Mon	h, Day, Year)
	F ≤ F Ö		Day 1	11	Q. on	1:10-	0		MUS	518		0	77/15	_
			30. Name and addre	ess of person who	completed cause o	death (Iten	n 23ą) (Type	Print	, 6	9.0	- Andy	7/2	71-1	
1	0+1		Jane	c. au	renjmi	~	1080	Bus	in a	NHC,	D 200	6		
	Sta		31. Date filed (Mont	th, Day, Year)		str s Signa	ature	1.	M D	1		J. 1		
	Regist	rar	1,	JUN -	1 2005 ▶	Contra	15	13931						

			1- State of Maryland / Department of Certificate Certificate	
>	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Demetrius Lamont Taylor 4a. Facility Name (If not institution, give street and number) 4b. City, Tox	2. Date of Death Month Day Year MAY 30 2005 07/5 M www, or Location of Death 4c. County of Death
	Funeral Director	*	Doctor's Community Hospital 5. Social Security Number 6. Sex 1 Months D 7. Age (In yrs. last birthday) If Under 1 Yrs. 1 Months D	
	D.	jo.	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George Bowie	10d. Inside City Limits 1 ☑ Yes 2 □ No
	ath with the s 23a or 28a-	Funeral Director	10e. Street and Number 10f. Zip Co 605 Juneberry Court 2072	United States
9800	d within 72 hours after death with the Maryland Jiene. r than "natural", or flems 23a or 28a-f show It e Madical Examilier rust bu redified at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent If Yes, specify	nt of Hispanic Origin? (Specify Yes or No-Cuban, Mexican, Puerto Rican, etc.) No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	d within glene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) Entrepre	done during most of working retired)
Maryland	d be antal ced c	To Be	17. Father's Name (First, Middle, Last) Eric Taylor, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S.	18. Mother's Name (First, Middle, Maiden Surname) Ceymon Gibbons Street and Number or Rural Route Number, City or Town, State, Zip Code)
	es 1 and 2 of Health a fitem 27 la r other tra		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of completery, crematory or other	
Baltimore,	permit. Pag Department Important: I any injury o			Address of Facility Er S. Pope Funeral Homes Liboro Pike, Forestville, MD 20747
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
8760,	Examine be executed whysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Aute 1 Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): d.	ria
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Rec		e Completed	25. Was case referred to medical	24a. Was an autopsy performed? 12 Yes 2 \(\subseteq \text{No} \) 26. Place of Death (Check only one)
Division of Vi	ttending Phys death. ctor: After this y the funeral di	Certification: To B	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of	Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number,
Ď	To the Hospital or A within 24 hours after To the Funerel Directorpletely filled in by	edical Cert	4 Homicide building, etc. (Specify) 29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier 29c. Li	29d. Date signed (Month, Day, Year) 0058446 6/01/2005
R	Sta Registi		30. Name and ad ress of per In who completed cause of death (Item 23a) (Type, Print) VOICHUK NOOTH 2 do M	0058446 6/01/2005 Good Luck Rd, Lan hun, MD 20706

DHMH 17 Rev 1/2001

	1	For State Registrar	State	of Marylai		artment of I rtificate of			Reg. No	2001	5 2	03	17
.Physicia:		1. Decedent's Name (First, Middle,						2. Date ofMonth	Da	y Ye	ar	I. Time of	
/Medica	al -		Mary Ja		e.			June		200		3:48	РМ
Examine	er	4a. Facility Name (If not institution, 2906 Montclair	•	imber)		4b. City, Town, o	cott Cit		40	. County of (HOWA			
		12.	6. Sex	7 Ane /In vrs	. last birthday)	tf Under 1 Year		Hrs. 8 Date of	f Birth	9		a (State or	r Foreian
Funeral Director		217 22 7867	1□M 215F	78	Yrs.	Months Days	Hours A	Min. (Month	$h^{Day, Year}$	927	Birthplace Country) Mary	land	
+ -		Usual Residence of Decedent									-		
nylan ihow		10a. State 10b. County			City, Town or Lo						10d.	tnside Cit 1 ☐ Yes	
Ba-f s	ct	MD Howar	d	F	llicot	-							2 3410
vith th		10e. Street and Number 2906 Montclair	Drizzo			10f. Zip Code 21043	2			tizen of Wha United			
or death with the Marylar tems 23e or 28e-f show etrmust be notified at	era	11. Marital Status		edent Ever in I	U.S. 13.	Was Decedent of		? (Specify Yes o		14. Race -			-
iter d	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie	Armed F	orces? 2 No		If Yes, specify Cub	an, Mexican, P	uèrto Rican, etc.)		White, etc.		
urs aft	þ	3 XWidowed 4 □ Divorced	If Yes, G Year or	ive Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify:	Whi	te	
filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23e or 28e-f show ent, the Medical Everyle art must be notified at	Completed	15. Decedent's (Specify only highest	s Education grade completed)	(Give	dent's Usual Occu	during most of	working	16b. K	(ind of Busin	ess/Indus	try	
ithin 16.	d d	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retire	ed)			Orm I	Iomo		
tygier ther ti	ဒီ	12 17. Father's Name (First, Middle, L	asti		П	omemaker	18. Mother's	Name (First, Mi	ddle. Maider	Own H	One		
ntal Hed ot	Be	William Gies	23 ()					Lochboe		,			
should be ind Mental in marked c	ဍ	19a. tnformant's Name/Relationshi	ip (Type, Print)		19b. Maili	ng Address (Stree	t and Number o	or Rural Route N	umber, City	or Town, Sta	te, Zip Co	ide)	
and 2 sealth ar n 27 is ner trau		Terry Pitt/Daug	hter		1591	6 Meadow	Walk Wo	oodbine,	MD 2	1797			
s 1 ar		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other pla	ace)	Dete	20c. L	ocation - Cit	y or Town	, State	
Pages nent of I int: if its ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		Cr		wn Mem. (-6-2005	Ma	rriott	svil	le, M	1 D
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturany injury or other traumatic event, trainedical 900.		21. Signature of Funeral Service L	icensee	MC		2. Name and Addr 112 Old (
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that	caused the deceach tine.	eth. Do not en	ter the mode of dy	ing, such as ca	rdiac or respirato	ory arr <i>e</i> st,		Int	oproximate tervat Bety	we <i>e</i> n
Physician		Immediate Cause (Final disease or condition	me me	40 Ca	Wial	infa	it so	01			ì	min (1 -
/Medical		resulting in death)	Due to	or as a conse	equence of):								
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eath certifice attending pl for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		⊒Ectopic pregnand	су			23d. Date of Month	f delivery Da	ιν ³	rear
e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 XNo 9 ☐ Unknown	4□ Preg 9□ Unk	gnant at time of nown	death 5	Other (specify)			-	***************************************		., .	ou.
hat th of by detach		Part II. Other significent condition	ns contributing to	death but not re	esulting in the	underlying cause o	iven in Part I.	23e.	Did tobacco	use contribu	ite to the c	cause of d	eath?
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The lav	mp								autopsy performed?	prio dea	r to compl th?	tetion of ca X∷No	ause of
	e C	25. Was case referred to medicat					26. Place of	1 ☐ Y f Death (Check of		0 1	Yes 20	ALNO	
Physician: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	thor	ing Home 5		6 Other	(Specify)		
ig Ph ter th	I: I	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dat	e of Injury onth, Day Yeer)	28b. Time o	of 28c. Inju	ury at ork?	28d. Desc	ribe how into	ry occurred			
Attending or death.	catio	2 ☐ Accident investig	ation				Yes 2□No		(2)		2 12		
or Att	Certification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Pla	ce of Intury - At ding, etc. (Spe	home, farm, si cify)	treet, factory, office	•		on (Street a	nd Number te)	or Hurai H	oute rvum	Der,
pitai ours a erai E		29a. Certifier 12 Certifying	p Physician: To t	he best of my k	nowledge dea	th occurred at the	time, date and r	place, and due to	the cause(s) and mann	er as state	ed.	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		The section of the section	to a site of more and			- Introduction of an about		i	- d - l	d of)
To th withir To th comp	Ň	29b. Signature and title of certifier	1 0		~	29c. Licer	nse number	0.1	29d. Da	ate signed (/	Month, Da	y, Year)	
		Dame	Leich	UP V	MO	1	278	28	J	une 2,	200	5	
5)02		30. Name and address of person	who completed ca	use of death (It	tem 23a) (Type	Print)	IL Noon	THE C	Louis	131A M	10.2	104	5
Can	•o	31. Date filed (Month, Day, Year)	ATLING 32.	F gistrar's Sig	2 ر Inature	120 NIVE				•			
Sta Registra		JUN 0 3	2005	Glower	J. A	Print) PSO KNO							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year **Physician** May 25, 2:21PM Mary Catherine White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock Trauma Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 21 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2🖺 F 75 218-24-9966 Virginia Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show s 23a or 28a-f show Frederick Brunswick 1X Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 "K" Street 21716 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other treumatic event, the Medical Exertiner ! Black, White, etc. e filed within 72 hours after If Hygiene. other than "natural", or Ite 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Fedders-Walkersville MD Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ent: If Item 27 is marked o John Wesley Robinson Bessie Virginia Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 "K" Street, Brunswick, MD 21716 19a. Informant's Name/Relationship (Type, Print) James Kenyon White, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/29/05 Green Hill Cemetery Berryville, VA 4 ☐Donation , 5 ☐ Other (Specify) 21. Signature of Luceral Sawice Lipensee William
Barbara A. Williams, Owner 22. Name and Address of Facility
John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Small Bowel Perforations resulting in death) /Medical Due to (or as a consequence of). Examiner 31 Days <u>Sepsis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Necrotizing Fasciitis resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitis 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an autopsy performed? Yes 2 No has page certificate 1 ☐ Yes rector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Xnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number June 2, 2005 ed cause of death (Item 23a) (Type, Print) 9 30. Name and address of person who M.D. Shock Trauma Center 22 S. Greene St., Balto., MD 21201 Tchaka B. Shepherd, 32. Projistrar's Signature State JUN 0 6 2005

DHMH 17 Rev 1/2001

Registrar

•		1 - For AMEND#7 per FH State Registrar 6/2/05 AACO HE	State of Maryland	/ Depa		lealth and	Mental Hyg		_	2032	20	
Physic	ian	1. Decedent's Name (First, Middle, Last)						Day 31	2 ^Y 005	3. Time of De	eath M	
/Med Exami	ical	Christine S. Wils 4a. Facility Name (If not institution, give:	4b. City, Town, o	r Location of Dea	May		unty of Death	1825				
		Anne Arundel Medi		Annapoli				e Arund				
Funeral Director		5. Social Security Number 6. Sep 031-01-3801 Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	Year)	Year) 9. Birthplace (State or Foreign Country) 1919 Massachusetts					
ryland how		10a. State 10b. County Maryland Anne Arur	del	Town or Lo					1	0d. Inside City		
Ba-f s	Director	,	Anr	napol:						1 ☐ Yes 2	LANO	
with the a or 2		10e. Street and Number	• =/		10f. Zip Code				of What Coun			
death ms 23	Funeral	2640 Queen Ann Circ	12. Was Decedent Ever in U.S.	. 13.	Was Decedent of H	lispanic Origin? (ted States 14. Race - American Indian,			
IIII INOTE, INBITIBING ZIZIO-UUJO init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If itam 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic avant, "to Modical Examinar must be rotified at injury or other traumatic avant," to Modical Examinar must be rotified at e.	b	1 ANever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:			to Rican, etc.)		Black, White, etc. Specify: white			
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within sne.	Completed	Elementary/Secondary (0-12)	Callege (1-4or 5+)		DO NOT use retire: rofessor	d)		Edi	Education			
TO ZIZI e filed within al Hygiene. I othar than vant, the We	a	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,					
Vian uld be Aental rked o	To B	James Wilson				Christi	na Smith					
Taryla 2 should and Men Is marke		19a. Informant's Name/Relationship (Ty			ng Address (Street			-				
e, IN 1 and 2 Health Isam 27 other tr		Neil H. Wilson/ br			Queen An		Annapol Date		0 21403 ion - City or To			
Dallimore, permit. Pages 1 ar Department of Hea Important: If itam any injury or otha		1 ☐ Burial 2 🎦 Cremation 3 ☐ F	emoval from State		osition (Name of matory or other place	l l						
Dallillo permit. Pages Department of Important: If i any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens			Cremato 2. Name and Addre		-2005				To	
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te be executed Wedical Examiner Weigen and Description We purish transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
The law requires that the death certificate be ex The has been signed by the attending physician range 2 should be detached for use as the burian	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Part II. Other significant conditions con	d	leath 3[th 5[□Ectopic pregnancy □ Other (specify) inderfying cause give		23e. Did to			ny Day Yea e cause of dea		
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DIVISION all or Attanding s after death. If Diractor: Afte	Certification	3 Suicide 6 Could not be 4 Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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To tha within 2 To tha complet	Σ	29b. Signature and title of certifier	. 60 0		29c. Licens			29d. Date si	gned (Month, I	Day, Year)		
		VSbert Sol	A Cden, MD		331	1050		6/1	05			
		30. Name and address of person who co			DICAL PK	MY AND	IAPALIS A	1) 2	1401			
S	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ILO ILO	A	WI TIM	110013/	10 6	1101			
Regis		JUN 0 2 20	05 Stone		souls!							

Watko, Bernard J.

	1	For State Registrer	Olaio (or warytar		rtificate of			Reg. No.	giene				
		Decedent's Name (First, Middle	e, Last)					2. Date of D	Date of Death Onth Day Voor					
Physicia /Medica	il,	Bernard Jam						June	02 02	2∞				
Examine	r	4a. Facility Name (If not institution The Memoric		4b. City, Town,	or Location of Deat	h	4c. County of Death Talbot							
Funeral		5. Social Security Number	al Hosp	7. Age (In yrs.	last birthday	If Under 1 Year		8. Date of B		-	rthplace (State or Foreign			
Director		189-12-9062A	1 ∑ M 2□ F	82	Yrs.	Months Days	Hours Min.	8. Date of B	-1922	Cla	arrton, PA			
Mo a	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation					10d. Inside City Limits			
ingo within to house area ocean must use way and Hygiene. ther than "natural", or items 23a or 28a-1 show ont, the Medical Examinational Descriptives at	į	MD Tal	bot	St.	. Mic	naels					1 ☐ Yes M☐ No			
23a or 28a-f show	Funeral Director	10e. Street and Number 9384 Marting	ham Dri			10f. Zip Code 2166	2		_	en of What C	country?			
18 23a	era	11. Marital Status	cedent Ever in U	IS 13		Specify Yes or N	USA	14. Race - American Indian,						
or items	ᇤ	1 ☐ Never Married 2X Marr	Armed F	Forces?		 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc					ite, etc.			
- 3	ρ	3 Widowed 4 Divorced	Year or	If Yes, Give Year or Dates: Navy		1□ Yes 2\ No			Specify: White					
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h and Mental Hygiene. 7 Is marked other than " fraumatic event, the Mar		Elementary/Secondary (0-12) 12 years				ice Man	ager		I	Inn				
al Hyg	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	-						
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Department of Health a Important: If Item 27 Is any injury or other tra		Agnes A. Wat	KO (W116	20b. F	93.6 Place of Disp	4 Martin osition (Name of	igham Di	Date St.	Mich 20c. Loc	acls ation - City	Md . 21663 r Town, State			
nt: If I		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (5		n State	-	matory or other pla l Crema		ne 4,20	05 D	over	De.			
Departm Importal any inju	- 1			1	21. Signature of Funeral Service Licensee									
2 2 2 3	110	R. Carroll Hurley FuneralHome, PC P O BONG, 5cl & gardistrespi Michaels, Md. April 663												
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State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Pay, Year) 2005

219 S. Washington St., Easton, Md. 21601
32 Registrar's Signature

DHMH 17 Rev 1/2001

amend item#28f, perME, G844, 6/20/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2005 5:10 p.m. Wheeler, Jr. June Charles Michael /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's 17641 Owensville Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 12 M 2 ☐ F Yrs. 27 1977 Director 216-13-2511 Maryland Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a State show Ever tree must be notified at 1 Yes 2 No Directo 28e-f Maryland Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 935 Chart Court 20657 United States Itams 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after ☐Yes 2 No 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical 12 should be filed within hand Mental Hyglene.
7 is marked othar thsn "r Elementary/Secondary (0-12) College (1-4or 5+) Production Operator Government Contractor 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Michael Wheeler 2 <u>Jeanette Arlene Redman</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) f Health item 27 935 Chart Court, Lusby, Maryland 20657 Jeanette Wheeler / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. 6-6-2005 Charlotte Hall, MD Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final de Physician VICI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Due to (or as a consequence of) attending physician P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 1 Yes 2 No Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 🕅 No u death. 2 Accident investigation 0301 1655 after death Director: 28f. Location (Street and Number or Aural Route Number, City or Town, State) 17641 Owensy; Rd. St. Inigoes, MD 20 6 Could not be determined 3 X Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ Owensyille MD 2068 4 🔲 Homicide filled in - ATher within 24 hours at To the Funeral D completely filled in 5 Brolence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cepifier D14285 June 6, 2005 30. Name and address of person leted cause of death (Item 23a) (Type, Print) 25365 Point Lookout Road, Leonardtown, MD 20650 William D. Boyd M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

faxidto m

32. Registar's Signature

2005

			1 - For State Registrar	State of M		epartme Certific				_	giene Reg. No.	11115	20324	
	Physici	20	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death	
	/Medic		Thomas Eugene Y	oung						June	4	_	6.4	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. C	ity, Town, o	r Location	of Death		4c.	County of Dea	ıth	
			Southern Marylan				Clinto]	Prince		
	Funeral		5. Social Security Number 6. Se	x 7. Ag M 2□F	e (In yrs. last birt	Mont	hs Days	If Under Hours	Min.	Date of Birt (Month, Da)	h y, Year)	9. Bir	rthplace (State or Foreign ountry)	
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	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits	
	Aaryl sho	ŏ	N 1 1 2 1	•									1 ☐ Yes 2 █ No	
	28a-1	Director	Maryland St. Ma	ary's			ngton Zip Code	Park	<u> </u>		10~ Citi	zen of What C		
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21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show diest Everning must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Ye	s 2 No	Specify:				Specify: B1a	ack	
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פַ	e filed al Hygie other vent, tt	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,				
<u> a</u>	uld by Aenta rked rlc e	ToE	Lawrence McLain	loung, Sr				Marg	aret	Louise	Bar	ber		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T)	ype, Print)	19b.	Mailing Addr	ess (Street	and Numbe	er or Rural	Route Numbe	r, City o	Town, State,	Zip Code)	
Σ	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree		Theresa Young / S	Sister	21	106 Wi	nding	Way,	Lexi	ngton	Park	, MD 20)653	
Baltimore,	of He of He item		20a. Method of Disposition		20b. Place of	Disposition (Name of or other place	ce)		ate		cation - City or		
Ĕ	Page nent on int: If		1 Burial 2 Cremation 3 F '4 Donation 5 Other (Specify)						6-10-	2005	Rid	ge, Mar	cvland	
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m	Depar Depar Impor any ir		Edward N. Brinsiie	Id, Ir	M00052	22955	Holl's	vwood	Road	. Leon	ardt	own. M	20650-0279	
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exemi	sicien: To the best iner: On the basis o	of my knowledge	, death occur	red at the tir	me, date an	nd place, ar	nd due to the o	ause(s)	and manner as	s stated.	
	the hin 2, the f	Jed	one)	and manner st	ated.									
	wit co-	Σ	29b. Signature and title of certifier	110 la			29c. Licens	e number			290. Date	e signed (Mont	n, Day, Year)	
,			10 redery	Mr Jph	MSicio	in	100	0 21	6.+	1-	6	15/9	25	
			30. Name and address of person who of	ompleted cause of o	leath (Item 23a) (Type, Print)	1 -	1	1 -			. 11	0 70700	
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State of Maryland / Department of Health and Mental Hygiene State Registra MEND#7perFH6/3/05, BMW, McCc Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 31, 11:20 PM MAY 2005 ZAREI EFFAT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SILVER SPRING 13604 TURNMORE RD. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2**X**□ F Director JAN. 22, 1930 IRAN 213-21-6252 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10a State 10b. County 1 Yes 2 □ No Directo MONTGOMERY SILVER SPRING MD. 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Innent of Heelth and Mental Hygiene. Int: If Item 27 Is markad othar than "natural", or Itema 23a or i "natural", or Itema 23a or 20906 13604 TURNMORE RD. IRAN Completed by Funeral Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALLAEDDINE ZAREI BATOOL ZAREI ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Pages 1 and 2 Department of Heelth a Important: If Item 27 Is NASRIN FALSAFI/DAUGHTER 13604 TURNMORE RD., SILVER SPRING, MD. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) NORBECK MEMORIAL PK. 6-4-2005 OLNEY, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A any in MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician OVARIAN CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Fijury Due to (or as a consequence of): Examiner burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): physicien Box 68760 hysician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Dther (specify) P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🛣 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After 5 Pending investigation 1 XNatural
2 Accide 1 ☐ Yes 2 ☐ No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0055938 JUNE 1, 2005 e and address of person who completed cause of death (Item 23a) (Type, Print) 10215 FERNWOOD RD., SUITE 315, BETHESDA, MD. 20817 KAVIANI, M.D. KIAN 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** JEO RGIA MAE EXANDER 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Hours 25/-84-6008 Usual Residence of Decedent Director SOUTH CAROLINA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 ROAD 621 or Items 23a 0 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I proportent: If tiem 21 is marked other then "naturel", or ther any injury or other treumetic event 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +HGRADE SABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ATHAR GERLENIA ဂ MACK ALEXANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 GIBSON ROAD, BALTO, MD. 21229 CHARLES LEAK 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ZION CEMETERYOG-18-05 LANSDOWNE, MO. 5 Other (Specify) 4 Donation 22. Name and Address of Facility, BROWN TR. FUN I 145 N. FULTON AVE. BALTO 21. Signature of Funeral Service icenses BROWN JR. FUNERAL HOM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myceartial Intarction /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an autopsy 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funerel Direct 29a. Certifier edical

Alexander Ceargia

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cectifier 172053849 w Legeron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) que Cater Avenue Baltimore navy land 21229 Beiger A5125 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

State Registrar JAMES BATTY 05-04099 RKD

			1 - State of Mary State of Mary Registrar		artment of H			ene 005	20327
			Decedent's Name (First, Middle, Last)				Date of Death Month	Day Ye	3. Time of Death
	Physici /Medic		James		Batty	Sr.	JUNE	15, 200	5 4:24P. M
Ż	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of I	Death
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	and *		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Aaryl sho	٥	MD NA I	Baltimor	. 6				1 XYes 2 □ No
	28e-1	ect	10e. Street and Number	Jar Crinor	10f. Zip Code		10	g. Citizen of Wha	t Country?
	with	۵	650 Hillview Road			1225		U.S.	
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent Eve	r in U.S. 13.	_1		ecity Yes or No-		American Indian.
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Baltimore,	permit. Pag Department Importent: f any injury o		21. Signature of Funeral Service Licensee	9 4		ash Ave			1d 21215
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	1		> Tool sullet M-		0	CME	т	UNE 16,	2005
	0		30. Name and address of person who completed cause of deat	h (Item 23a) (Tyne	Print)	<u> </u>			
	9		ZABILLEAH ALI		III Pe	nn Street	Raltım	ore, Mar	yland 21201
	Sta Regist		JUN 2 0 2005	Signature	perte				

Anthony Boyce 05-04130 NJM

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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City L	imits
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Baltimore,	or or		1 Suburial 2 ☐ Cremation 3 ii		0	emetery, cre	matory or ot	her place		CC 511/1			-		
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	Regist		JUN 2 0 2		180	I B	parte	,							

DHMH 17 Rev 1/2001

			1- For Amend Item 4a State of Maryland / Department of Health per phy G844 6-20-05 tas Certificate of Death	and Mental Hygid h	ene2005 20329
	Dhusisi	7A.	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	3. Time of Death
	Physici /Medic		FIENRY JOSEPH XJURIWELL	JUNE.	11, 2005 4:00 PM
1	Examin	er	_ Jobeph Richey Hobbice		4c. County of Death
3				F 24 Hrs. 8. Date of Birth	2 Pithpless (State or Foreign
	Funeral Director		219-22-397/ 12M 20F 76 Yrs. Months Days Hours		(ear) 9. Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent	1001,20	1150 MARYZAND
	anylan show	L.	10a. State 10b. County 10c. City, Town or Location	~ ~	10d. Inside City Limits
	8a-f	ecto	MARYLAND NIA PALTII	YORE CIT	1 Nes 2 No
	with t	Dir	10e. Street and Number 10f. Zip Code	1213	QCitizen of What Country?
	ns 23	Funerai Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	Origin? (Specify Yes or No-	14. Race - American Indian,
9	or Ita	Fur	Armed Forces? If Yes, specify Cuban, Mexica 1 Never Married 2 Married 1 Never Married 2 No	an, Puerto Rican, etc.)	Black, White, etc.
5-0036	72 hours after death with the Maryland natural', or llarns 23a or 28a-f show dicel Evantret must be notified at	d by	3 ☐ Widowed 4 Ø Divorced If Yes, Give Year or Dates:	y: 	Specify: BLACK
5	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mantal Hygiene. Item 27 Is marked other then "natural", or Itams 23a or 28a-1 show titem 27 Is marked other then "natural re notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Sive kind of work done during mo life. DO NOT use retired)	ost of working	6b. Kind of Business/Industry
2121	filed within Hygiene. kther then "	dmo	Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIV	ER	-OOD INDUSTRI
	i Hyg other	Be C		her's Name (First, Middle, Ma	
Maryland	outd be Mental larked o	To B	JOHN WESLEY CARTER FO	LOSSIE	BURTWELL
ar)	2 shoutd and Men Is marke sumatic	·	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)	ber or Rural Route Number,	City or Town, State, Zip Code)
	1 and Health em 27 other tr		OLIVIA THOMAS (DAUGHTER) 3407 TERES	ACT. BAL	TIHORE, MD. 21213
Baltimore,	00 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location - City or Town, State
<u>#</u>	it. Pag intment intent: I njury o		*4 □ Donation 5 □ Other (Specify)		
Ba	permit. Page Department Important: Il any injury o		1 1/1, Mayor TOSEPH It	LILTON AVE	R. FUNERAL HOME BALTO, MD. 21217
	4.		23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such a		t, Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Interval Between Onset and Deathy
	/Medical		resulting in death) Due to (or as a consequence of):		GA IMOGA
	Examiner		Sequentially list conditions, b.		
	ed Isit	Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury		
•	xecut and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
68760,	icate be executed physician and s the burial-transit	edical E			
Вох	leath certific attending p I for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	it the dea by the ati tached fo	Physician/M	in the past 12 months? 1		Month Day Year
P.0	The taw requires that the death certif ate has been signed by the attending page 2 should be detached for use a			t I 23e Did toba	cco use contribute to the cause of death?
Records,	uires that signed t id be det	d by	MAMO WHIT		2 No 3 Probably 4 DUKnown
COL	w require been sign	lete	71/4	24a. Was an	246. Were autopsy findings available
Re	The tav te has age 2	Completed	THOMAIR CORDUSTAL NISPACE	autopsy performe	prior to completion of cause of death?
Vital		0	25. Was case referred medical 26. Plac	1 ☐ Yes 2 0 ce of Death (Check only one)	No 1
		To B		Nursing Home 5 Residen	ce 6 Dother (Specify)
n of	fter free			28d. Describe how	injury occurred
Sio	Attending r death. ector: After by the funer	cati	2 Accident investigation M 1 Yes 2		,
Division	or At after of Direct in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	et and Number or Rural Route Number, State)
_	spitel lours naral filled			and place, and due to the cau	se(s) and manner as stated.
	To the Hospitel or within 24 hours after To the Funaral Director Completely filled in the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	eath occurred at the time, date	and place, and due to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Month, Day, Year)
\wedge	1)	1	/ * 18 WW W 18 W/W WD / 1901.	2	1/12/05
1	XV.	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	El Bitta	MI 21210
	Sta	10	31. Date filed (Month, Day, Year) 32. Registrar Signature	y consul	119 21045
	Sta Registr		NION 9 / 2005 Medica 25		

			State of Marylar	nd / Depa		Health and N	Mental Hyg		0 0 5	203	30
Physi /Med		1. Decedent's Name (First, Middle, Last) Ella Mackey	Bussey				2. Date of Dea June	1 ^{Day}	20ඊ5	3. Time of D	P M
Exam		4a. Facility Name (If not institution, give si Gilchrist	treet and number)		4b. City, Town, Towson	or Location of Death	1		ounty of Death Itimore		
Funera Directo		213-20-0030	м 2X F 7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth June 23	, ^{Yea} [9]	9. Birth May	place (State or Mand	Foreign
Maryland -f show fied st	tor	Usual Residence of Decedent 10a. State Md. Baltimore		ty, Town or Lo	cation					10d. Inside City	
with the 3s or 28c	i Director	10e. Street and Number 615 Chestnut Ave.			10f. Zip Code	21204	1	0g. Citizer	n of What Cou		
72 hours after death with the Marylar 72 hours after death with the Marylar natural; or Itams 23a or 28e-f show tologal Examinat must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates:	J.S. 13. \	Was Decedent of f Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		Race - Amer Black, White becify:		
within the same of	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire ducator	pation a during most of won ad)	king		of Business/li	ndustry	
Ø = 0 ≥	To Be C	17. Father's Name (First, Middle, Last) Louis Hergenra				Elizabe		h	·		
		19a. Informant's Name/Relationship (Typ Mr. Thomas Bussey/	Son	1581	Jarrett	tand Number or Ru Sville Rd	. Jarret				4
Department of Hear mportent: If item any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		1top S	sition (Name of natory or other pla ervice C	o. 6-18	-05	Tows	on, Md.		
permit. Page Department (Importent: If any injury or	ouce.	21. Signature of Funeral Service License	° 12	22	Nam and ddr	ess of Facility SOLL FUREY R Rd. Tow	al Home,	Ins.)4		
Physicia /Medica	_	23a. Part1. Ent if the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused he deal e cause on each ine.	th. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and De	een eath
Examine	r	Sequentially list conditions, if any, leading to immediate	Due to (or as a ponsec	quence of):	regent o	175ph mg	14			mont	lus
ite be executed sysician and ne burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	A (A)	SiA					year	
death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	dc. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3□	Ectopic pregnance Other (specify)	у		230	. Date of delive Month	ery Day Ye	ear ear
requires that the de leen signed by the a	þ	Part II. Other significant conditions cont	,	_	nderlying cause g	ven in Part I.	23e. Did tot	_		the cause of dea	
The law ate has the page 2 s	Completed		,				24a. Was a autops perform	v	4b. Were autoprior to condeath?	opsy findings avoid and the second se	/ailable use of
Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Ye} \) No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ot		th <i>(Check only on</i> ome 5 ☐ Reside		Other (Speci	m (fospi	æ
utending Phy death. ctor: After this y the funeral d	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	iry at ork?] Yes 2 □ No	28d. Describe ho	w injury o	ccurred		
or direction by the property of the property o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)			28f. Location (St City or Town	, State)			ЭГ,
To the Hospitel within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	ation and/or inv	estigation, in my	opinion, death occur	rred at the time, da	ate and pla	ice, and due t	o the cause(s)	
Total Comp	W	29b. Signature and talle of certifier 30. Name and address of person who con 31. Date filed (Month, Day, Year)	tily, in	2	29c. Licen	se number	2	d. Date s	igned (Month,	Day, Year)	
10		30. Name and address of person who com W. A. R. Lay	npleted cause of death (Iter	m 23a) (Type,	Print) L. Charl	les St. E	Palto.	nd	2:20	۶	
Regis	State strar	31. Date filed (North, Day, Year) 2005	32. Registrar's Signa	ature form	K)						

		4	State of Maryland / State of Maryland / Registrer	•	rtment of He tificate of L			giene Reg. No.	05	20331
			Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death
	Physicia		Charles R. Bennett				06		2005	1130 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Coun	ty of Death	
			GENESIS SEVERNA PARK			A PAR	_			CONDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign ntry)
	Director		213-34-0858 67	Yrs.			June	11 1938	Mary	yland
	and w	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	eation				1	I Od. Inside City Limits
	Aaryl sho	5	Maryland Anne Arundel Pasa	idena	1					1 Yes 2 No
	28a-	ect	10e Street and Number	idelle	10f. Zip Code			10g. Citizen o	What Cour	ntry?
	with March		186 Strohm Drive			21122		11	SA	
	ns 2:	era	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No		ace - Americ	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked othat than "natural", or Itams 23e or 28e-f show othat treamatic event, the Medical Examinar must be notified at	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Dates:	1	Yes, specify Cubai	Specify:	Rican, etc.)	Spec	ack, White, lify: Wh	etc. nite
Ŏ	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Deced	ent's Usual Occupa kind of work done d	ition	dina	16b. Kind of	Business/In	dustry
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	O NOT use retired,)	.		-	1.0
21	od wi	Son	12 0		Salesman					ol Company
nd	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	•		-	
₹	Men Men arke	ပ္	Charles L. Bennett			Juanita			Graw	0.41
Jar Jar	2 sh and Ism reum		100.		g Address (Street a					
e)	l and lealth im 27 ihar t	1 19			Strohm Dr:		Date	20c, Location		
0	it of H	1	132 Burial 2 Cremation 3 Hemoval from State	-	sition (Name of natory or other place				•	, Maryland
Baltimore,	rtmer rtent rtent njury		*4 □Donation 5 □Other (Specify) GIEN 21. Signatury of Funeral Service Licensee	-	en Mem. Pl . Name and Addres		3-03	Gren b	urnite,	, rial yland
Ba	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		Valences (Kannih	Mg 32	Cully-Po 204 Mount	lyniak Fu ain Road			A. rylano	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Due to (at as a consequence)	Re	Mireton	Failer				
	/Medical Examiner	19	resulting in death) Due to (** s a consequence	e of): 🖊	0					
	=xa	e	Sequentially list conditions, if any leading to immediate Due to (or as a consequence	e of):						
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Elter the bettyking Cause (Disease or injury that initiated events cause)	•						
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8760,	icate be executed physician and s the burial-transit	dicail	d							
9	tificat ig phy as thi	0 1								7
.O. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
Δ.	that	by Pt	Part II. Other significant conditions contributing to death but not resulting				23e. Did	tobacco use co	ntribute to t	he cause of death?
rds	quires in sign uld be	De De	Non Small Cell Ling Concer	214	Z Brein		1 🗆	Yes 2□No	3 Prob	bably 4 🗆 Unknown
Vital Records,	aw requir s been si 2 should	Completed	Non Small Cell Long Concer Motastasis, Esophagitis				24a. Was			opsy findings available ompletion of cause of
æ	The law cate has page 2	E O						ormed?	death?	2 No
ital		Bec	25. Was case referred to medical			26. Place of Dea	th (Check only	one)		
>	S S S	일	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatien	t 3 DOA Othe	or: 4 X Nursing H	ome 5□Res	idence 6 🗆 0	ther (Specif	<i>(y)</i>
n of	ding Ph h. After th funeral		27. Manner of Death 1 ► Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury occ	urred	
<u>S</u> i	Attanding ir death. ector: After by the fune	catle	2 Accident investigation			Yes 2 □ No				
Division	if or Attand after death Director: / d in by the f	Certification;	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		City or To	wn, State)	nber or Hura	al Route Number,
	To tha Hospital or At within 24 hours after d To tha Funarel Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled and manner stated.							
	To the To the Comp	Me	29b. Signature and title of certifier		29c. License	number		29d. Date sign	ned (Month,	Day, Year)
			1 1/1/2-12	100	De	1825		06/	15/20	205
١	2%		30. Name and address of person who completed cause of death (Item 23:	a) (Type,	Print)	, 0	1 0	Λ	L 11	A 2
	-01	ate	31. Date filed (Month, Day, Year) 32. Bigistrar's Signature	9	LT Truck	house 16	seve	son flat	K, IVE	11146
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R2YNALAG LEE - LLACER F, MD, 24 Truckhouse Rd, Sewerum Park, MD 21146 State Registrar 31. Date filed (Month, Day, Year) JUN 2 0 2005 32. Designature									

			For State Registrar	State of N	Maryland	/ Depa	irtment of F tificate of	lealth and <i>Death</i>		giene Reg. No.	005	20332
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	hysicia		CHARLOTTE	D.	BENNET	$^{\circ}\mathrm{T}$			Month	Day	200 5	8. ISA M.
	/Medic xamin		4a. Facility Name (If not institution	, give street and numbe	or)		4b. City, Town, o	r Location of De	4.77	4c. C	ounty of Death	
	Admin		North Arunde	1 Hospital			Gle	n Burni	e		Anne Ar	undel
Fu	neral		5. Social Security Number		Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th	9 Birth	place (State or Foreign
	ector		212-44-15 38	1 ☐ M 2 🗗 F	59	Yrs.	Months Days	Hours M	in. (Month, Da	25 , 194	46 Mar	yland
g			Usual Residence of Decedent									
rylan	E		10a. State 10b. County		10c. City,							10d. Inside City Limits
e Ma	iffe and	cto	Maryland Anne	Arundel	P	asade	ena					1 ☐ Yes 2 No
th th	97.0	lre	10e. Street and Number				10f. Zip Code			_	n of What Cou	ntry?
th wi	228	Funeral Director	8423 Rugby Roa	ıd			2	1122		Ţ	J.S.A.	
dea	E E	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. s2	13. V	Vas Decedent of F	lispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14	Race - Ameri Black, White,	
after	100	F	1 Never Married 2 Marri	ed 1 ☐ Yes 2 If Yes, Give			☐ Yes 2 No	Specify:	,,			
Source	E S	d by	3 Widowed 4 Divorced	Year or Dates	s:						pecify: Whi	ce
72.1	dica	Completed	15. Decedent (Specify only highes			(Give	ent's Usual Occup kind of work done	during most of w	vorking	16b. Kind	of Business/In	dustry
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lygie	T E		47 Fashada Nama (First Middle)				Couri		lana (Final Middle		st Diag	nostic
be fi	6 VB	Be	17. Father's Name (First, Middle, I						lame (First, Middle		1	
2 should be filed within 72 hours after death with the Maryland and Mentle Hygiene.	natic	ဥ		lein		401 14 15		Eliza		lechal		2
2 st	itam 27 is markao omar man 'natural, or tams 23a or 20a-1 snow othar traumatic evant. The Medical Examinar must be notified at		19a. Informant's Name/Relationsh						Rural Route Numb			·
1 and Health	thar	1	Harley L. Benn 20a. Method of Disposition	ett (Husba			Kugby K sition (Name of	oad, Pa	sadena, M		ind ZII.	
Pages 1	- io	- 6	1 Burial 2 Cremation	3 Removal from State	te cem	etery, cren	natory or other pla				·	
. Pa	jury		' 4 □ Donation 5 □ Other (Sp	and the same of th	lou		ark Cem.		7–05	Bal	timore	, Maryland
permit. Departn	any injury or conce.		21. Signature of Funeral Service	3tensee	1/	Mc ²²	Name and Addre	ss of Facility 1yniak	Funeral H d, Pasade	Home F	.A.	
9 602	- a O		Jun S.	James 1							laryland	
			23a Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death. I line.	Do not ente	er the mode of dyir	ng, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Phys			Immediate Cause (Final disease or condition	- Drust	I M	1000	rdial	Mar	dion			Oriset and Death
	dical niner		resulting in death)	Due to (or s	s a consequer	e of):						
Exall	iiiiiei		Sequentially list conditions.	b h	mg	can	10er-					
D	ii.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequer	nce of):						
ecute	trans	am	that initiated events resulting in death) Last	С								
cate be executed	pnysician and the burial-transit		resulting in death) Last	Due to (or a	as a consequer	nce of):						
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artific	e as	Mec	IF FEMALE:	11								
ath co	or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3	Ectopic pregnancy	/		23	d. Date of delive Month	ery Day Year
9 de	ned fo	SC	1 ☐ Yes 2 7 No	4☐Pregnant 9☐Unknown	at time of deat	h 5 🗆	Other (specify) _				WOTE	Day Teal
atth	etach	Physician/Me	9 Unknown					- 1- D 1	00 - Did 4			
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equin e	pino	ted							- '4	¥es 2□	No 3 Proc	pably 4 DUnknown
law r	2 6	ple							24a. Was		24b. Were auto	psy findings available mpletion of cause of
The)ac	Completed							perfo	rmed?	death? 1 ☐ Yes	
ian:	director, pag	Be (25. Was case referred to medical examiner?					26. Place of D	eath (Check only o	orle)		
ysic	dire	10 T	1 ☐ Yes 2 No	Hospital: 1 Inpa	itient 2 EF	VOutpatien	1 3□ DOA Ott	er: 4 🗌 Nursing	Home 5 Resid	dence 6[Other (Specif	y)
- B	Arren in funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, L	njury 28 Da <i>y Ye</i> ar) 28	3b. Time of Injury	28c. Injui Wor	y at k?	28d. Describe	how injury	occurred	
andir	the fu	atle	2 Accident investig	jation				Yes 2 □ No				
r Att	by t	tific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 286. Place of I	Injury - At home etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (: City or Tox		Vumber or Rura	I Route Number,
ital o	led in	Certification:										
lospi hou	ely fill.	edical	29a. Certifier 11 Certifying (Check only 2 Medical I	g Physician: To the bes Examiner: On the basis	st of my knowle	edge, death	occurred at the tirestigation, in my	ne, date and pla	ce, and due to the	cause(s) ar	nd manner as s	tated.
To the Hospital or Attanding Physician: within 24 hours after death.	completely filled in by	ledi	one)	and manner	stated.	. allow of fifty						
P	COL	Z	29b. Signature and title of certifier		,		29c. Licens				signed (Month,	
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10			30. Name an ress of person v	who completed cause of	f death (Item 2	3a) (Type, I	Print	11	demi		1.2101	11
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Patient Mnash as Elizabeth Bernstein

State of Maryland / Department of Health and Mental Hygiene 20333 1-State Registrar amend item #19a per fh 894%/c&te20 De5thJH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 16, 2005 Year 3:49 P M BERNSTEIN ELIZABETH /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE N/A SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth DECONTO 649, 1912 9. Birthplace (State or Foreign Country) VA 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 📆 F 92 Yrs. 215-42-0892 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ¥Yes 2 No Be Completed by Funeral Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3202 TANEY ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 💢 No WHITE Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental **FARMER** MILDRED YEATTS CHARLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENHAMIN BERNSTEIN / SON Health tam 27 5136 ELDER ROAD - HYDES, MD 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or * 4 ☐Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY 6/17/2005 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter shock, or he the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, last failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 2 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 □Unknown 1 Yes 2 No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed? 2 **X** No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) Hospital: ္ 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 ho To tha Funs completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier d 30. Name and address of person who completed gause of death (Item 23a) (Type, Print State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#27, perME, G844, 6/22/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20334 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Curtis Jerome 11:00a.M 6 8 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner 1701 Eutaw Place 219 Apt. Baltimore NA 8. Date of Birth (Month, Day, Year)
1-20-35 If Under 1 Year If Under Months Days Hours 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min Months Country) MD 1 XM 2 □ F 70 Director 216-30-0626 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show other treumatic avant, the Medical Exercites must be notified at Y Yes 2 □ No Director Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Items 23g U.S.A. 219 21217 1701 Eutaw Place Apt. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2√☐No Yes. Give 1 Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: ρ Specify: If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r filed within Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Printer Wells Printers na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel P. Randall John C. Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 slowtheart of Health and cartant: If item 27 is n 1604 East 30th Street, Baltimore, Md 21218 <u>Flavia James-Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 4 □Donation 5 □ Other (Specify) Metro Crematory Inc 6/18/05 Baltimore, Md permit.
Deports
Imports
any njk Baltimore, Md. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility 21215 4300 Wabash Ave. nes March F.H. West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician metrstake /Medical Due to (or as a consequence of): **Examiner** M KHOULV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a co sequence of): Examiner autin the attending physician and and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 þe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by This muture 1 Yas 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Other: 4 Nursing Home 5 Judence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After To the Hospital or Attanding 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier low de 30. Name and address of person who complety A ause of death (Item 23a) (Type, Print)

State

Registrar

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31. Date filed (Month)

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2005

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MP

Registrar's Signature

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			State Registrar 1. Decedent's Name (First, Middle, La	actl		Cei	tificate of	Deam	2. Date 0	Reg. N	o: 0 0 0	3. Time of Death
	Physici /Medic		Helen		Col	es			Month O (D.	ay Year 2005	8:48 AM
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			2314 W.	Moshe			5		more		NA	<u>' </u>
	Funeral Director		519-28-5334	Sex 1 □ M 2 💢 F	ge (In yrs. Ia 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Monti	of Birth h, Day, Year	r) Cou	place (State or Foreign intry)
	and and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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	h the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
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	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S ?	13.	Was Decedent of H f Yes, specify Cub	lispanic Origir an, Mexican, F	n? (Specify Yes of Puerto Rican, etc	or No-	14. Race - Amer Black, White	
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2☐ If Yes, Give Year or Dates:	HN 0		1 □ Yes 2 🗷 No	Specify:			Specify: Z	\ \
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altimore,	0 0		1 Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec		9		Ridge		22/05	Ell	Kridge,	MD
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	ensee My It	n	22					TON & SON MD 21217	NS F.H., INC
	-		23a. Part. Enter the disease, or cor	nplications that cause	d the death.	Do not ent					IID ZIZI,	Approximate Interval Between
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0.	the a	Physiclan/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Uлknown	4□Pregnant a 9□Unknown	at time of dea	ath 5∐	Other (specify) _	-				
۵.	that the de ned by the a detached		Part II. Other significant conditions	contributing to death	but not resul	ting in the u	nderlying cause giv	en in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
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		Com	IN continence	e of Bo	wel	6- B	ladder		1 🗆 Y	pertormed?	death?	
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of	Physic this cral dir	2	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1 🗆 Inpat	ient 2 E	R/Outpatier 28b. Time of	IL 3 DOX	100			6 ☐Other (Speci ury occurred	(fy) -
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) Sta	to.	Allen Keilly 31. Date filed (Month, Day, Year)	3 Regis	F EAST	to A	uing so	iss La	, 51 6 5		ח יוייו ח	- 1 - 0
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, Funeral Director			8. Date of Birth (Month, Day,) 8/29/193	9. Bi (ear) MAF	thplace (State or Foreign ountry) YLAND
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with the E or 28 Everui	Director	10e. Street and Number 10f. Zip Code 8102 RIDGELY OAK ROAD 21234	100	g. Citizen of What C USA	ountry?
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re, Maryla s 1 and 2 should. f Health and Men item 27 is marke other treumetic.		19a. Informant's Name/Relationship (<i>Type, Print</i>) LEONARD CIOTTA, SR./HUSBAND 8102 RIDGELY OAK ROAD			Zip Code) 1234
of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of DISPOSITION OF DISPOSITION (Name of DISPOSITION OF DISPOSITION OF DISPOSITION (Name of DISPOSITION OF	ate 20	oc. Location - City o	Town, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe once.		1 Donation 5 Other (Specify) 21. Signatury of Funeral ervice Licensee 22. Name and Address of Facility THE 8521 LOCH RAVEN ELV.	JOHNSON	FUNERAL	
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58 / 60, icate be executed physician and s the burial-transit	cal	d		N	
Hecords, P.O. Box 68 The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1		23d. Date of de Month	elivery Day Year
rdS, P. quires that the signed by the deta	ρ	Tark to the organical control of the	23e. Did toba		o the cause of death?
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t VItal F nysicien: Th nis certificate director, pag	o Be (25. Was case referred to medical examiner?		ce 6 □Other (Spe	T.
on o ding Ph h. After th funeral	\vdash		28d. Describe how		outy)
DIVISION Of VITA Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certific tely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or F State)	tural Route Number,
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To the within 2 To the complet	M	29b. Signature and title of certifier 29c. License number D38655		DI. Date signed (Mon	
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	~~~	23371 /35175	The sale of the sa
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			Registrar 1. Decedent's Name (First, Middle, I	l act)		erinicale or	Dealli	2. Date of Dea	Reg. No:	3. Time of Death
	Physicia	an	Mark	Andrew	Callana	n Sn		Month	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, g		Carrana		r Location of Deat	1 000	4c. County of De	
	LAGITITI		102 Park Lane			Baltim	ore		N/A	
	Funeral		5. Social Security Number 6	Sex 7. Age ((In yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h 9. E	Birthplace (State or Foreign Country)
	Director		213-72-6122	ILAM ZLIF	47 Yrs.			June 1	1,1958	Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	Location				10d. Inside City Limits
	Mary f sho	jo	Maryland N/A		Bali	imore				1 □ X Yes 2 □ No
	r 28a	rec	10e. Street and Number		241	10f. Zip Code			10g. Citizen of What	Country?
	th with	Funeral Director	102 Park Lane			21210			U.S.A.	
	ams	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite. etc.
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 💢 No	Specify:		Coorie	110 4 4 0
Ö	within 72 hours after death with the Maryland ene. Than "natural", or llams 23a or 28a-f show re Medical Exardinarunt be invittled at		15. Decedent's	Year or Dates:	16a Dec	edent's Usual Occup	ation		16b. Kind of Busines	lhite
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DHMH 17 Rev 1/2001

Registrar

JUN 20

2005

			For State Registrar		laryland / De	partment of Hea	alth and M	lental Hygi		20339
	Physici /Medic Examin	al	Decedent's Name (First, Mice Brenda 4a. Facility Name (If not institute Maryland	Ge	orgette	Dav		2. Date of Death Month June		
No	Funeral Director		5. Social Security Number 214-58-8013 Usual Residence of Decedent	6. Sex 1 M 2 X F	ige (In yrs. last birthd	Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01 23	Year) 9. 52	Birthplace (State or Foreign Country) MD
	ath with the Maryland 23s or 28e-f show	irector	MD NA 10e. Street and Number		Baltim			10	g. Citizen of Wha	10d. Inside City Limits MYes 2 □ No t Country?
980	after death or Items 23	by Funeral Director	1701 Eutaw 11. Marital Status 12. Never Married 2 M 3 Widowed 4 Divorce	12. Was Deceder Armed Forces arried 1 Tyes 2	t Ever in U.S. 1?] No	212 3. Was Decedent of Hisp If Yes, specify Cuban, I		ecify Yes or No- Rican, etc.)		• A • American Indian, White, etc. Black
121215-0036	s within 72 jiene. r then "nei	Completed	15. Deced (Specify only high Elementary/Secondary (0-12 12th grade 17. Father's Name (First, Midd	lyr+	(G lif	ecedent's Usual Occupation ive kind of work done during to NOT use retired)	ing most of worki	ng		
land	o d ta b	To Be	George Coate				dna Da		alden Sumame)	
nore, Maryland	Pages 1 and 2 should be fment of Health and Mental tent: If item 27 is merked i jury or other treumatic ev		19a. Informant's Name/Relatio Jessica Merc 20a. Method of Disposition 1 □ Burial 2 □ Frematio 4 □ Donation 5 □ Other	er-Daughte	20b. Place of Di	ailing Address (Street and Parkview sposition (Name of crematory or other place) Crematory	Number or Rura Ave A	Pate D P		re Md 2120 or Town, State
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service		7	22. Name and Address of March F/H 4300 Wabas	of Facility West			
68760,	Certificate be executed with physician and with physician and with properties as the burial-transit	edical Examiner	23a. Part 1. Enter the disease, shock, or heart failure. L'Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. CO TO NO Due to (or a c.	ed the death. Do not	enter the mode of dying, s	ascardiac o	Trespiratory arres	is.	Approximate Interval Between Onset and Death UCCS Years Years.
.O. Box	that the death certifics ed by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
ords, P	w requires that the death been signed by the atten should be detached for u	by	Part II. Dther significant cond	itions contributing to death Diables N	but not resulting in th	e underlying cause given i	n Part 1. LENSION			e to the cause of death? Probably 4 Unknown
Division of Vital Records,	The farate has page 2	e Completed	25. Was case referred to medi	cal		26	S Place of Death	24a. Was an autopsy perform 1 Yes 21	prior death	
of Vi	Physicien: this certific ral director,	To B	examiner? 1 \(\text{Yes} 2 \(\text{No} \)	Hospital: 1 ☐ Inpai		tient 3 DOA Cther.	4 Nursing Hon		ce 6 Other (S	Specify)
ono	ng After	tlon:	27. Manner of Death 1 Natural 5 Pen	28a. Date of Indiang (Month, Date)	ay Year) 28b. Time Injur	y Work?	2 No	28d. Describe how	injury occurred	
Division	To the Hospitel or Attending Vaithin 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Cou	id not be 28e. Place of I	njury - At home, farm, atc. (Specify)			28f. Location (Stre City or Town,		Rural Route Number,
	e Hosp 124 hou e Funei letely fil	edical	29a. Certifier 1 Certification (Check only one)	ying Physician: To the bes al Examiner: On the basis and manner s	of examination and/o	eath occurred at the time, r investigation, in my opini	date and place, a on, death occurre	and due to the cau ad at the time, dat	se(s) and manner e and place, and o	r as stated. due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certi	Haril	Mus	29c. License nu	158		d. Date signed (Ma	05
2) 1		30. Name and address of person	who completed cause of	death (Item 23a) (Ty)	pe, Print)	+ Suite	407 B	alti moe	e, MB 21201
	Sta Registr		31. Date filed (Month, Day, Yea	32 Aegis	trar's Signarine	pare			-	, - , - , - , - , - , - , - , - , - , -

	r	•	For State Registrar	•	artment of Health and M rtificate of Death	ental Hygiene Reg. No 005 20340
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year 3. Time of Death
	/Medic		JOE DAWS			JUNE 15 , 2015 8.45 "
	Examin	er	4a. Facility Name (If not institution, give street a NORTHWEST HOSPITI		4b. City, Town, or Location of Death RANDAUSTOWN	4c. County of Death BALTIMORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
	Director		243.16.2693 1EM 21	□F Q1 Yrs.	Months Days Hours Min.	(Month, Day, Year) Country) 04.02.1914 NC
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	nation	10d. Inside City Limits
	the Marylan 28e-f show notified at	5	MD BALTIMO			1 ☐ Yes 2 🗗 No
	28e-	rect	10e. Street and Number	CL CINTING	10f. Zip Code	10g. Citizen of What Country?
	23a or	Funeral Director	3313 RETLAW ROAD		21207	USA
	deat	ner	11. Marital Status 12. Wa	s Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	
36	or It	by Fu	1 Never Married 2 Married 1 II	Yes 2 □ No es. Give	1 ☐ Yes 2 M No Specify:	
5-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-1 show idical Examinar must be nutilised at	ed b	3 Nuidowed 4 □ Divorced Yes	ar or Dates:	dent's Usual Occupation	Specify: BLACK 16b. Kind of Business/Industry
215	n "na Nedic	piet	(Specify only highest grade comp	(Give	kind of work done during most of workir DO NOT use retired)	ng
212	filed within Hygiene. other then "	Completed	4 (1)	N A SIE	EL WORKER	BETH. STEEL
	S 4 2 8	To Be (17. Father's Name (First, Middle, Last)	•		(First, Middle, Maiden Sumame)
Maryland	Ment Ment Marked	은	JOE DAWSON			OLEY
Ma	d 2 sho h and 7 Is mu traum		19a. Informant's Name/Relationship (Type, Printer DAWSON (DA			I Route Number, City or Town, State, Zip Code)
	is 1 and of Health item 27 other tr	1	20a. Method of Disposition	20b. Place of Dispo	REILAW ROAD., BA	ate 20c. Location - City or Town, State
<u>o</u> E	Pages ent of nt: If it		1 Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State GARRISON	FOLEST 06.21	.05 OWINGS MILLS MO
altimore,	permit. Page Depertment o Important: If any Injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address of Eacility LUGHN C. GREENE FUN	
ä	Depermine Depermine Brown in B		12 augh	51	51 BAYO. NATU PIKE	BAYD. 90 21229
П			23a. Part1. Enter the disease, or complications shock, or head failure. List only one caus			r respiratory arrest, Approximate Interval Between
	Fhysician	0 4	Immediate Cause (Final disease or condition	TENSIVE ISLUE	MIA OR STOMA	Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence of):		
		ē	Sequentially list conditions, b.	ue to (or as a consequence of):	EL OBSTRUCTIO	J.M.,
	uted d ansit	듵	cause. Enter Underlying Cause (Disease or injury	Penilmala		
o,	be executed icien and burial-transit	Examin		ue to (or as a consequence of)		
8760,	ate by he	Physician/Medical	d	Politored Y	nelimonia"	
9		Mec	IF FEMALE:			
Вох	that the death certific ed by the attending p detached for use as	lan	in the past 12 months?		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
o.	the de	ysic		Unknown	Other (specify)	
Δ.	requires that the een signed by th nould be detache	by Pt	Part II. Other significant conditions contributing	g to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds	w requires been sign should be					1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	- Q 7/2	Completed				24a. Was an autopsy findings available prior to completion of cause of
l R	The ate h page	E				performed? death? 1 Yes 2 No 1 Yes 2 No
/ita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one)
of	phys this al di	2	1 ☐ Yes 2 ☐ No Hospita 27. Manner of Death 28a	1 X Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time of		ne 5 Residence 6 Other (Specify)
on	ffer in a	tion	1 Natural 5 Pending	(Month, Day Year) Injury	f 28c. Injury at 2 Work? M 1 Tyes 2 No	ad. Describe now injury occurred
/isi	Attending r death. sctor: After by the fune	fica	3 Suicide 6 Could not be	Place of Injury - At home, farm, st		28f. Location (Street and Number or Rural Route Number,
ā	el or s afte el Dire	Certification;	4 Homicide	building, etc. (Specify)		City or Town, State)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (29a. Certifier 1 X Certifying Physician: (Check only 2 Medical Examiner: Or	To the best of my knowledge, deal	h occurred at the time, date and place, a	and due to the cause(s) and manner as stated. In a stated and place, and due to the cause(s)
	the H hin 24 the F nplete	Medi	one) an	d manner stated.	29c. License number	
.	To Your	-	29b. Signature and title of certifier	12hla m.D	DUIGIO	June 15th, 2 cos
7	5		30. Name and address of person who complete			
	3°		MONTH JET 1101 PT	TAL CENTER	Print JOGINDER P RAHDAUSTOWN	MEHTIA 21133.
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 Ming Chinas IV Will	1110 711~3
	Regist	rar	JUN 2 0 2005	leding to loss	W	

DHMH 17 Rev 1/2001

ORIGINAL

-0403				Type or Prin				•	9	
rriet D	L. Dan	es	ie For Unpend Item	23a&27 per	me G844-	Atificate of	Health and N B eath		ene .g. n2 0 0 5	20341
	Physicia	ın	1. Decedent's Name (First, Middle, La Harriet L.	Danesie		• • •		2. Date of Deat June 13	_	3. Time of Death 0256A. M
	/Medic Examin		4a. Facility Name (If not institution, given 12 Cedar Drive A	e street and number)		4b. City, Town, C	or Location of Death		4c. County of Death Baltimore	_1
PULS	Funeral Director		Social Security Number 6. S		(In yrs. last birthday 49 Yrs.			8. Date of Birth (Month, Day, July 8,	Year) 9. Birth	place (State or Foreign intry) O., Maryland
47	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
:	the Mar	Director	Maryland Baltimon	ce	Middle R	iver		1/	Og. Citizen of What Cou	1 ☐ Yes 2 ☐ No
7	23a or	ral Dir	12 Cedar Drive Ap	pt. B			1220		USA	•
036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. itiam 27 is markad othar than "natural", or itams 23a or 28a-f show itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
Maryland 21215-0036	ithin 72 ho le. lan "natur Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business/Ir	ndustry
1d 21	Hygier Othar th ant, th	Be Cor	7 17. Father's Name (First, Middle, Last,)	H	omemaker	18. Mother's Nam	e (First, Middle, N	Own H	ome
ylan	should be ind Mental in markad c	To B	Harry Warren				·		ecca Starl	-
	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (Michael A. Danesie	* * *		-			City or Town, State, Zi, Ver Maryla	·
ore,	Pages 1 ar nent of Hea int: If itam iry or otha		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □		20b. Place of Disp cemetery, cre		-	_	20c. Location - City or T	
			' 4 □ Donation 5 □ Other (Specification 21. Similar of Funda 1. rvice Lice	y)			7 Inc 6/14		Baltimore, B Si Funeral B	Maryland
e e	permit. Departr Imports any inji		4-3	$\frac{1}{2}$	1	407 old E	Eastern Av	enue Ess	ex Marylan	
	/-km		23a. Rart1 Efter the disease, or comshock or heart failure. List only Immediate Cause (Final disease or condition						st,	Approximate Interval Between Onset and Death
	Mysician /Medical Examiner		disease of condition resulting in death)	u	consequence of):	TOVASCUTA	r Disease			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underfun Cause (Disease or injury	b. Due to (or as a	consequence of):					
	be executed sician and burial-transit	Examiner	Cause Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
-	le be ysicia e bur	ca		_ d						
. Box 68	ine aw requires that the death certificate is the has been signed by the attending physic page 2 should be detached for use as the branched for use as the branched for use as the branched for use as the branched for use as the branched for use as the branched for use as the branched for use as the branched for use as the branched for the branch	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome o 1∐Live birth 2 4∐Pregnant at ti 9∐Unknown	Fetal death 3	□Ectopic pregnanc: □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
ırds, P.	w requires that the debase signed by the should be detached	ed by Ph	Part II. Other significant conditions of	contributing to death but	not resulting in the	underlying cause gr	ven in Part I.		acco use contribute to t	t/
Division of Vital Records, P.O	aician: The law re certificate has be lirector, page 2 sho	Completed						24a. Was an autopsy perform 1 X Yes 2	prior to co	opsy findings available impletion of cause of
f Vit	Attending Proyatcian: r death. actor: After this certific. by the funeral director.	To Be	25. Was case referred to medical examiner? 1 ★★★ es 2 □ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3□ DOA Ott	26. Place of Death ner: 4 Nursing Ho		nce 6 🖔 Other <i>(Speci</i> i	(scene)
o uc	After th		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo	ry at	28d. Describe how		,,
Divisio	after death Diractor:	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		y - At home, farm, si (Specify)			28f. Location (Str. City or Town,	eet and Number or Rura State)	al Route Number,
		Medical C	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	th occurred at the ti	me, date and place, opinion, death occurr	and due to the car red at the time, da	use(s) and manner as s te and place, and due to	stated. o the cause(s)
	withi To the	2	29b. Signature and title of certifier	tallan	nd		ocmE		d. Date signed <i>(Month,</i> June 13, 20	
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type		enn Street	Baltim	ore, Maryla	and 21201
	Stat Registra		31. Date filed (Month, Day, Year) JUN 2 0 2005	82. Registrar	's Signature	<i>V.</i> .				
	riegistic	"	2014 % 0 7803	A STORE	NS PERSON					

			State of Maryland / Depar		-	•	
			FUI	rificate of Death	Reg.	0000	2021.0
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
П	/Medic	al	MICHAEL STEVEN GOLDBERG	4b. City, Town, or Location of Death		6 2005 4c. County of Death	3:35 PM
	Examin	er			dr	BALTIN	NORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth		lace (State or Foreign
Н	Director		220760059 45 Yrs.	Months Days Hours Min.	1173/1959	MARY	LAND
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation		1	Od. Inside City Limits
	Mary a-f sh	ţō	MD N/A BALTIMO	ORE CITY			1X Yes 2 □ No
	with the	Direc	10e. Street and Number 1810 EAST PRATT STREET	10f. Zip Code 21231	10g.	Citizen of What Cour	ntry?
	ns 23	era		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	city Yes or No-	14. Race - Americ	
920	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or tems 23a or 28a-f show event, the Medical Examinar must be notified at event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2/1 Married 1 TVes 2/1 No	Yes, specify Cuban, Mexican, Puerto l □ Yes 2 <mark>X</mark> No <i>Specify:</i>	Rican, etc.)	Specify: WHI	
2-0	72 ho	eted	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	ent's Usual Occupation	16b	. Kind of Business/Inc	•
121	within iene. than	Completed		ind of work done during most of working NOT use retired) C CLERK	BAI	LTIMORE CI	TY JAIL
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The most standard of the transparent is seen to the transparent any injury or other traumatic event, the Medical Examinar must be routified at once.	To Be C	17. Father's Name (First, Middle, Last) MORRIS H. GOLDBERG		(First, Middle, Maid		
Mary	d 2 should th and Men 7 is marke traumatic	ľ		Address (Street and Number or Rura MARK LANE JACKSON		y or Town, State, Zip 28546 – 78	
ē,	s 1 and f Health item 27 othar tr		20a. Method of Disposition 20b. Place of Disposi			Location - City or To	
E E	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREM	MATORY, INC. 6/18	3/2005 CA	TONSVILLE,	MD
Balti	permit. Departn Importe any inju		- // // Al. //	Name and Address of Facility THE 521 LOCH RAVEN BLY			
			23a. Part . Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
F	hysician /Medical	20. 1	resulting in death)	ARREST			Olisa, and Death
	Examiner		Due to (or as a consequence of):	15 040000	MUNDAT	U U	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Property of the Court of	CHROLO	10140111	7	
	ecuted ind transii	Examiner	that initiated events				
760,	ate be executed nysician and he burial-transit	cal Ex	350 (0 (0) 25 25 150 457)				
	ficate g physics ts the	****	d.				
Box	h certi ending use a	M/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel death 3 □ E	Ectopic pregnancy		23d. Date of delive	•
о В	that the death certifica led by the attending ph detached for use as th	ysicia		Other (specify)		Month	Day Year
Vital Records, P.O.	Attending Physicien: The law requires that the death certifica death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the und MELAS SYNDROME	derlying cause given in Part I.		23e. Did tobacco use contribute to the cause of de	
COL	w requires to been signer should be o	iete		_	24a. Was an	24b. Were autor	osy findings available
Re	The la ate has bage 2	omo			autopsy performed? 1 ☐ Yes 2 ☐ 1	prior to cor death?	npletion of cause of
/ital	cien: ertifica ector, p	Bec	25. Was case referred to medical examiner?	26. Place of Death			
of o	Physic this c al dire		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ patient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of			6 ☐Other (Specify)
0	ding I th. After funer	tion	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury 28b. Time of Injury	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	ilary occurred	
Division of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Street City or Town, Sta	and Number or Rura ate)	Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	Medical C	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death of the control of my knowledge, death of the contro	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, I	Day, Year)
	do		Mingoroum M.D.	T18443	_ 6	1160	S
h	5		30. Name and independent person who completed cause of death (Item 23a) (Type, Pr TALDEEP HINGO RANT 560)		BLVD	BALTIN	WRE MD.
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		コレマリ	JAMIL IIV	WELL, MID.
	Registr		JUN 2 0 2005 Reserve A.	Sports			

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760.

			For 1 State Registrar	State of	Maryland .		artmen tificate			and M		giene Nog. No.	005	203	44
			Decedent's Name (First, Middle, L.	ast)							2. Date of Dea Month	th Day	Year	3. Time of D	eath
	Physicia /Medic		Thomas Christ	opher Hes	ss						June 1			11:30	PM^{M}
	Examin		4a. Facility Name (If not institution, g	ive street and numb	ber)		4b. City,	Town, or	Location of	of Death			nty of Death		
			22190 Bull Ro				Leon						Mary		
	Funeral	7.		Sex 7 1 ☑ M 2 ☐ F	. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 25	Yeer)	9. Birth	plece <i>(State or F</i> ntry) insylvan	=oreign
	Director		209-07-2699	X 2	90	115.					May 25	, 1913	rei	msylvan	ııa
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City	Limits
	f sho	0	MD St. Ma	rv¹s]	Leona	rdtow	m						1 🗌 Yes 2	X No
	28a-	Director	10e. Street and Number	25 0			10f. Zip					10g. Citizen o	of What Cou	ntry?	
	be filed within 72 hours after death with the Maryland tal Myglene death with the Maryland other than "natural", or items 23a or 28a-f show defeat other than Medical Evantinar must be rediffed at event, the Medical Evantinar must be rediffed at		22190 Bull Ro	ad				2	20650			Ţ	JSA		
	death ms 2	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S.	13.	Vas Deced	lent of Hi	ispanic Ori	gin? (Spi	ecify Yes or No- Rican, etc.)	14. A	ace - Ameri		
٥	or ite		1 ☐ Never Married 2 X Married				1 Yes		Specify:		r mouri, oto.,	Spec		white	
200	hours after tural', or ite	d by	3 Widowed 4 Divorced	Year or Dat	les: '38–48										1.
2	72 h	Completed	15. Decedent's (Specify only highest of	Education grade completed)	1	(Give	dent's Usua kind of wo DO NOT us	k done o	<i>duri</i> na mos	t of work	n <i>g</i>	16b. Kind of	Business/Ir	idustry (unk
2	han .	dm	Elementary/Secondary (0-12)	College (1-	4or 5+)		cks da		•	or					
N	filed within 72 Hygiene. other than "natent, the Medic		12 17. Father's Name (First, Middle, La			100	.ks u	ill O			(First, Middle,	Maiden Sum	ame)		
Maryland 21215-0036	ntai h	Be c	Thomas Christo		S				A	1ma	Teresa '	Withro	w		
2	should by nd Menta marked umatic e	၉	19a. Informant's Name/Relationship	-		19b. Mailir	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	r, City or Tow	m, Stete, Zi	o Code)	
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Ruth Hess/spo	ouse		2219	0 Bu	L1 Ro	oad L	eona	rdtown,	MD 2	0650		
Baltimore,	s 1 and f Healt item 2 other	1	20a. Method of Disposition		cem	e of Dispo	sition (Nar	ne of ther plac	(a)	Ţ	Date	20c. Locatio	n - City or T	own, State	
9			1 ☐ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Special Control C		late	0.0.7, 0.0.									
			21 Stonetur — Funeral Service Lice S	ensee	rector	27	Name an	d Addres	ss of Facili	Xard	655 W.	Balti	more S	Street	
ñ	permit. Departr Import any inj		minil.	111/2	TO LOT		ltimo			2120					
760,	Nacion and harding transit are but are but are but are but are but are but are transit are but are transit are but are transit	Examiner	23a Part 1. Enter the disease, or od stock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c) Due to (c)	Puls	nce of):	ary ary	FE	all all	Du Ing	e Der)		Approximate Inn vival Betwee Oriset and D	
	ate b	licai		d			+							/	
89	ing pl	Med	IF FEMALE:	00-11			100								
.O. Box	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live bii	come of pregnance th 2 Fetal de tot at time of deat wn	ath 3	Ectopic pi						Date of delive Month	Day Ye	ar
Records, P.	signed by	þ	Part II. Other significant conditions	s contributing to de	ath but not resulting	ng in the u	nderlying o	ause give	en in Part I			obacco use co 'es 2 🖾 No		the cause of dea bably 4 □Un	
000	w requir been si should	Completed	Dema	ntia s	molu						24a. Was		b. Were aut	opsy findings av	allable
Re	ician: The lav certificate has rector, page 2	d Li	1011-0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0							rmed?	death?	ompletion of cau 2□ No	ISO OT
Vital	n: Ti ficate or, pa	e Co	25. Was case referred to medical		0				26 Place	e of Deat	1 ☐ Yes		1 195	2[] 140	
	ysician: The is certificate ha	o B	examiner? 1 ☐ Yes 2 😰 No	Hospital:	patient 2 EF	R/Outpatie	nt 3□ D0	Oth Oth	or		me 5 Resid		Other (Spec	ify)	
on of	fing Ph	—	27. Manner of Death 1 2 Natural 5 Pending 2 Accident investiga	28a. Date o (Month		8b. Time o Injury		28c. Injun Wor			28d. Describe h				
Division of	To the Hospitei or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ertification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At homing, etc. (Specify)	e, farm, st	reet, factor	y, office			28f. Location (S City or Tox		mber or Rui	rai Route Numbe	97,
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in b	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the caminer: On the ba	sis of examination	edge, deat n and/or in	h occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the cred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)	
	Fo the within Fo the	Me	29b. Signature and title of certifier	01		4 1	29	c. Licens	e number			29d. Date sig	ned (Month	, Day, Year)	
)	- > - 0		1 Dine	y T. Ha	NOF	7/11	\ -	DC	64	19		6-6-	-05		
			30. Name and a press of person w	no completed cause	e of death (Item	a) (Type.	Print)	n	0	+	11.		0	1 -	1
			James P. Jaba	a let	who Be	un	Medi	cal	Cer.	ler	Hal	lyw	000	mda	0634
		ate	31. Date filed (Month, Day, Year)	nns Re	egistrar s Signatur	Con	de					IJ	1		
	Regist	rar	N O L	And the same	A 8 4 42 MA	1									

			For State (artment of Health and Martificate of Death		iene	20345
			I. Decedent's Name (First, Middle, Last)			2. Date of Death Month	h Day Year	3. Time of Death
	Physici /Medic		Thomas Lee Holt				9 2005	3:50 A ^M
	Examin	er	a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death		4c. County of Deat	
			lospice of Baltimore Gil		TOWSON If Under 1 Year If Under 24 Hrs.	2 Date of Birth	Baltimore	
	Funeral		S. Social Security Number 6. Sex 1 M 2 □ F	7. Age (In yrs. last birthday) 63 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, July 2,	Year) Co	nplace (State or Foreign untry)
	Director		Jsual Residence of Decedent	03		buly Z,	1941 Mar	yland
	yland how		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	e-fs	ctor	MD Baltimore	Cockeysvil	l le			1 ☐ Yes 2 ☐XNo
	or 28	Oire	Oe. Street and Number		10f. Zip Code	10	og. Citizen of What Co	untry?
	ath w	Funeral Director	10815 Powers Avenue		21030		ISA	
	er de	nue	Amed F	cedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
30	rs aft	by F	1 Never Married 2 Married 1 X Yes If Yes, G 3 Widowed 4 X ivorced Year or I	2 No ive Dates:	1 ☐ Yes 2 🂢 No Specify:		Specify:	ite
2-003p	d within 72 hours after death with the Maryland jene. r than "naturel", or tlems 23e or 28e-f show the Medical Examinar must be notified at		15. Decedent's Education	16a. Dece	dent's Usual Occupation	. 1	16b. Kind of Business/	
2	hin 72 In "ni	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(Give (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ring		
7		mo:	12		ess Owner	R	estaurant	
2	be filed Ital Hygid od other event, Ital	Be (17. Father's Name (First, Middle, Last)			e (First, Middle, N	Maiden Sumame)	
yland	Dexo	2	Lee Holt		unknown			
Mar	C1 40 00 00		19a. Informant's Name/Relationship (Type, Print) Blair T. Holt / so		ng Address (Street and Number or Rui			
	s 1 and f Health Item 27 other tr		· · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo	S. Pacific Coast		20c. Location - City or	
altimore,	Pages 1 nent of H ant: If Ite ary or ot	-	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from	State cernetery, crei	matory or other place)			IOWII, State
=======================================	t. Pa rtmer rtent: rjury		* 4 □ Donation 5 □ Other (Specify) 21. Signature ■ Finefal Service Licensea		Service Corp. 6/20 2. Name and Address of Facility	1/05	owson, MD 1050 Yo	ule Dood
a n	permit. Pages Department of Importent: If I eny injury or once.		21. Signature in Findral Service Licensing		uck Towson Funeral	Home		MD 21204
		-	23a Part1. Enter the disease, or complications that					Approximate
	West and		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one callse on Immediate Cause (Final	1 -	Carlinge	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	o (or as consequence of):	TALLOVE	, .	-	Lucers
	Examiner			Alcoholic	: cirrhosis e	1 hver	1	meritas
	me, en	Je.	Sequentially list conditions, if any, leading to mineriate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):	(= = =	
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
oʻ	an an rial-tr		resulting in death) Last Due to	(or as a consequence of):				
9/60	The law requires that the death certificate be executed tens been signed by the attending physician and tage 2 should be detached for use as the burial-transit	licai	d					
Õ	eath certifica attending ph I for use as th	Mec	IF FEMALE:		1000			
XOX	ath ce	Physician/Me	23b. Was decedent pregnant 1 23c. If yes, 0		Ectopic pregnancy		23d. Date of del Month	ivery Day Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk		Other (specify)			
J.	that the de ned by the a detached t		Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
g Q	sign d be	d by	aspiration pre	unurua		1 ☐ Ye	s 2 kNo 3 Pr	obably 4 Unknown
Vital Records,	w require been si should b	Completed				24a. Was ar	24b. Were au	topsy findings available
ĕ	has ge 2	d L				autops	y prior to oned? death?	completion of cause of
<u></u>		e Co	25. Was case referred to medical		26 Place of Dee	1 ☐ Yes 2 th (Check only one	PANO 1 □ Yes	2□ No
	ysicie is cert directe	To B	examiner? Hospital:	Inpatient 2 ER/Outpatie	Othor		ince 6 AOther (Spe	city) Homer Ce
O	g Phy er thi		27. Manner of Death 28a. Date	e of Injury 28b. Time onth, Day Year) Injury		28d. Describe ho		1120
Division	Attending F death. ctor: After y the funer	atio	1 ÄNatural 5 □ Pending (Mo 2 □ Accident investigation	india	M 1 Yes 2 No			
<u> </u>	r Atte er de: recto by th	Certification:	3 Suicide 6 Could not be determined 28e. Place buil	ce of Injury - At home, farm, st ding, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town	reet and Number or Ru , State)	ıral Route Number,
ā	itel or rs aft el Dii	Cer		7,				
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification completely filled in by the funeral director.	edicai	(Check only 2 Medicel Examiner: On the		th occurred at the time, date and place, evestigation, in my opinion, death occur			
	To the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of certifier	1 . 17	29c. License number		9d. Date signed (Monta	
	F S F O		1 Master	Meleg uns	1)25005	5	Dar 19,	2005
1	3+1		W. A. Riley (-6m		. Charles St.	Ber Cto	Md 200	2c/E
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 0 2005	Registrar's Signature				
24	5,121		OUT LOUD ALE	125 Pt 19 100				

DHMH 17 Rev 1/2001

6-19-05 C.3:50 RM

Thomas Holt

DHMH 17 Rev 1/2001

Registrar

		,	State o	i Maryland	-	artment of F ctificate of a	lealth and M <i>Death</i>		iene	15	20347
	Physici	an	Decedent's Name (First, Middle, Last)	Ann Hen	lev			2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If not institution, give street and nur				r Location of Death	June 15	4c. County		000 7
			SAINT AGNES HERM	ICATE		B#	If Under 24 Hrs.	/		N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. las 58	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 12	Year) 1946		ace (State or Foreign ry) land
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10	d. Inside City Limits
	Maryl R-1 sho	tor	Maryland N/A			Ba	altimore				1 Yes 2 □ No
	with the	Director	10e. Street and Number 511½ Charing	Cross R	d.,	10f. Zip Code	21229	11	0g. Citizen of W		ry?
	death ms 234	Funeral	11. Marital Status 12. Was Dece	edent Ever in U.S.		Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecity Yes or No-	14. Race	- America	
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination of the property.	by Fur	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes, Gin 3 ☐ Widowed 4 ☐ Divorced Year or D	2 X No		r Yes, specify Cuba 1 ☐ Yes 21∑ No	Specify:	rican, etc.)	Specify	k, White, e	
21215-0036	72 hou 'natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	lent's Usual Occup	ation during most of worki	ing	16b. Kind of Bu	siness/Indi	ustry
121	iene. rthan *	Completed	Elementary/Secondary (0-12) College (1)	-4or 5+)	life. I	DO NOT use retired Homemal	•		Housewi	fe &	Mother
פו	be filed tat Hyg d other	Be C	17. Father's Name (First, Middle, Last)	D 1	C		18. Mother's Name		Maiden Sumam	θ)	
Maryland	hould to d Ment marked matic	ဥ	Thomas E			og Address (Street	Ethel and Number or Rura	J. Warr	City or Town	State Zin (Code)
	alth an 27 Is i		John Walter Henley, Jr.			-	ng Cross		-		
ore.	ges 1 a t of He if item or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from	Cen	ce of Dispo	sition (Name of natory or other place w Mem. Pl	(80	Date	20c. Location -	City or Tov	
Baltimore.	mit. Pa bartmen sortant; injury 20.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Lak				12			Tiai y Laiid
ä	permi Depar Impor any ir		I fihr F. Colles	is			ss of Facility olyniak Fu tain Rd.,				
	8		23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e Immediate Cause (Final	aused the death.	i		ng, such as cardiac d	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	(or as a conseque		515				5	gears
	Examiner	<u>.</u>	Sequentially list conditions, b	or as a puriseque	noe oft						
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
×8760.	ficate be executed physician and is the burial-transit	al Exa	resulting in death) Last Due to	or as a conseque	ence of):						
1, 0	tificate be ng physicia as the bur	fedical	d					-			
No.	death certific e attending p od for use as	Physician/M	in the past 12 months?	come of pregnand	leath 3	Ectopic pregnancy	,		23d. Date Mor	of deliver	y Day Year
70	that the de ed by the a detached f	hysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unkn	ant at time of dea	ith 5L	Other (specify)					
F. P.	ires that the de signed by the d be detached	by	Part II. Other significant conditions contributing to d	ath but not result	ting in the u	nderlying cause giv	en in Part I.		acco use contr		cause of death?
cord	w requ been shoul	leted						24a. Was a	I		sy findings available
Z Re	t ician: The lav certificate has rector, page 2	Completed						autops: perform	y p ned2 d	rior to com	pletion of cause of
AA Vital	Physician: this certificaral director, p	Be	25. Was case referred to medical examiner? Hospital:			. ac pos Oth	26. Place of Death				
100	ding Phys .r. After this i	n; To	27. Manner of Death 28a. Date		R/Outpatien 28b. Time of Injury	IL 3 L DOA	4 🗆 Nursing no	me 5 Reside 28d. Describe ho			
Division	Attending death. ctor: Afte y the fun	catio	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Divi	after d after d Direct	Certification;	determined 286. Place	of Injury - At hom ng, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St. City or Town		er or Rural	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	asis of examinatio	ledge, death on and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occurr	and due to the ca	use(s) and mai ate and place, a	ner as sta	ited. the cause(s)
_	To the within 2 To the complet	Med	29b. Signature and title of contier	ner stated.		29c, Licens	e number	29	9d. Date signed	(Month, D	Pay, Year)
	2		> Kydy Hora	4 Atter	della	DO	061564	1	6/15	105	
	H		30. Name and address of person who completed cause RYAN HOWARD 900	e of death (Item 2	23a) (Type)	Frint) BALT	Timore,	md. 2	1229		
	Sta		31. Date filed (Month, Day, Year) 32	legistrar's Signatu	ire d	ale					
	Regist	rair	JUN 2 0 2005	المر روبول	19						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2005 EDWARI 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTOCHERY MA NEIL ASHTNGTON HOS PITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Fo **Funeral** -12-6145 1**5** M 2□ F Director Usual Residence of Decedent Douth Caro 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "neturel", or Items 23e or 28e-f show the Medical Exerti at must be notified at Monta Director Maryland 1 ☐ Yes 2 ☑ No omery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20 Funerai Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 6 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ar rendy ပ um 19a. Informant's N e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree Date Joc. Location - City or Town, State Stockton Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 21, 2005 1 inde 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility S 2222 W. North Funeval Home, P.A. W. North Aveo 21216 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Class Cause of I jury Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 90 1 Yes 2 No 3 Probably 4 Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed pade After this certificate 1 Yes 21 No 1 Yes To the Hospitel or Attending Physicien: uneral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Outpatient 3 DOA Certification: To 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ospitel c. 44 hours after dea... rel Director: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 60310 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DARCIE MNERC 7600 CARROLL AVE. TAKOMA PARK Md. 31. Date filed (Month, Day, 32. Begistrar's Signature Year) Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 16, 2005 11:42 A Ann Elizabeth Ibex /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2X F 52 Yrs. 1952 11, Director 220-50-4259 Dec. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show or then "neturel; or items 23e or 28a-f show The Medical Exportment bust be notified at 1 ☐ Yes 2 No Directo Baltimore Lutherville Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 1400 Belmore Court by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1.2 should be filed within 7: h and Mental Hygiene. 7 Is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna R. Mettee Bernard E. Ibex 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lutherville, Maryland 21093 1400 Belmore Court Mrs. Anna R. Ibex/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grd. 6/20/05 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) no si 5 Physician ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of a Examiner physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical SS attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 280 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and atle of certifier June 16, 2005 W 30. Name and address of person who completed cause of death (16m 23a) (Type, Print) Chales St. Falt. Md 2120x 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 0 2005 Registrar

June 16, 3005

		1- For State of Maryland / Dep	partment of Health a	ind Mental	l Hygien	UUU	20350
		Decedent's Name (First, Middle, Last)			of Death		3. Time of Death
Physic		Richard Jerosimich		June		2005	2:43 PM
/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of			c. County of Death	
Lxaiiii	ICI	8400 Echo Drive	Pasadena		A	nne Arun	de1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		24 Hrs. 8. Date Min. (Mor	of Birth	9 Birth	place /State or Foreign
Director		217-34-2578 1⊠M 2□F 70 Yrs.	Months Days Flours	July	1, 1	934 Mar	yland
pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	conting				10d. Inside City Limits
aryla shov	<u>_</u>	Maryland Anne Arundel Pasadena	cocation				1 ☐ Yes 2 🗷 No
8e-f	acto		10/7: 0:4:		10= 0	itizen of What Co	
vith ti	Ē	10e. Street and Number	10f. Zip Code 211	22		USA	antry?
s 23	Funeral Director	8400 Echo Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13				14. Race - Amer	ican Indian
er de Itam	in.	11. Marital Status 12. Was Decadent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 ★ No	. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	, Puerto Rican, e	tc.)	Black, White	
rs aft	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		i	Specify: Wh	ite
2 hou			edent's Usual Occupation		16b. I	Kind of Business/l	ndustry
nin 77	Completed	(Specify only highest grade completed) (Given Secondary (0-12) College (1-4or 5+)	re kind of work done during most DO NOT use retired)	t of working			
d with	E	12	Self employe	d		Builder	
othe vent,	BeC	17. Father's Name (First, Middle, Last)		r's Name (First, I	Middle, Maide	n Sumame)	
ld be denta rked lic ev	To E	Vaso Jerosimich	Mild:	red	Pa	jic	
shou shou	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number	ar or Rural Route	Number, City	or Town, State, Z	ip Code)
alth a			Echo Drive, P	asadena,	Mary1	and 2112	.2
S 1 g		20a. Method of Disposition 20b. Place of Discernetery, or	position (Name of ematory or other place)	Date	20c. L	ocation - City or	Town, State
Page nent c			en Memorial Pk.	06-16-05	5 Gle	n Burnie	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, the Modical Examinating must be notified at another.		21. Signature of Funeral Service Licensee	McCully—Polynia 3204 Mountain R	k Funera	1 Home	P.A.	d 21122
		23a. Page. Enter the disease, or complications that caused the death. Do not e				riai y i ai.	Approximate
		shock, or heart failure. List only one cause on each line.	_			ļ	Interval Between Onset and Death
Physician /Medical		disease or condition a.	Cancer				20 years
Examiner		Due to (or as a consequence of):					
	e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
nsit	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
axecu n and al-tra	Examiner	that initiated events resulting in death) Last c					
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be delached for use as the burial-transit	cal	C _d					
ficate g phy as the		u.					
uires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3				23d. Date of deli	very
death death defor	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
oy the ache	hys	9 Unknown					
s tha	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e	. Did tobacco	use contribute to	the cause of death?
w require been sig					1 ☐ Yes 2	No 3□ Pro	bably 4 Unknown
aw requ	Completed			24a	. Was an autopsy		opsy findings available ompletion of cause of
The ta	Eo			10	performed?	death?	2 No
Bn: liffica	0	25. Was case referred to medical	26. Place	of Death (Check		0	
ysici is cer direct	OB	examiner? 1 Yes 2 No	ent 3 DOA Other: 4 Nur	rsing Home 5	Residence	6 ☐Other (Spec	ify)
g Ph g Ph	n: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury		28d. De	scribe how inju	ury occurred	
ath. e fur Aft	atio	Natural 5 Pending (World), Day Year) Injury 2 Accident investigation	M 1 Yes 2 N	No			
Atta er de: ecto by th	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Loca City	ation (Street a	and Number or Ru te)	ral Route Number,
s afte	Certification:						
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Check only Control of the Dest of Management (Check only Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Control of the Dest of Management (Check only Check on Check					
the H in 24 the F iplete	Medicai	one) and manner stated.					
To To corr	2	29b. Signature and title of certifier	29c. License number			ate signed (Month	
-6		Jeanine weiner, MV)	D52830		-0,	ne 13, a	5001
-01		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)				
5		i - "	1 11-3		g = 0	44.00	5 . 1
8		Jeanine Weiner, MP 900 Bestage	H Road #300	Anna	apolis	MO?	21401
St	ate		te Road #300	Anne	apolis	, MO	21401

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day :33AM 2005 Ohnson 4c. County of Deeth 4b. City, Town, or Location of Deeth ecility Neme (if not institution, give street end number) Daltimore If Under 24 Hrs. R Data of and town If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 9. Birthplece (State or Foreign 6. Sex 1 1 M 2 □ F 7. Age (In yrs. lest birthday) Yrs. 5. Social Security Number Deys Hours Months Mary 220-07-3203 Usuel Residence of Decedent -30 -1916 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Many Land 10e. Street end Number Ba Itimore 10g. Citizen of What Country? 10f. Zip Code . Was Decedent Ever in U,S. Armed Forces?, 1 | Yes 2 No If Yes, Give Year or Dates: 20 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stewart Annie King ohnson 19a. Informant's Name/Relationship (Type, Print) (aug htz) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto, Mp 21202 1014 20c. Location - City or Fown, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 21 Brooks 105 6 Chapel Cemete 22. Name and Address of Facility Cemeter 4 ☐ Donation 5 ☐ Other (Specify) of Juneral Service Licenses eph neval Home, P.A. 108 1222 Ave. Balto. North 23a. Part1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Final diseese or condition resulting in death) CORONARY ARTERY Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hriknown ARDIOM Y OPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? MYPERTENSION 1 TYUS 2 LINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

ed by the attending physicien end detached for use es tha burial-trensit requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, completely filled in by tha funeral diractor, To the Hospital or Attending Phys within 24 hours after deeth.

To the Funeral Director: After this

Physician

/Medical

Examiner

Funeral Director

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Completed

Be

Examiner

Physician/Medical

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Completed

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Certification: To

Medicai

Funeral

Director

Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at

12 should be filed within 72 hours n end Mental Hygiene. Is merked other than "natural",

permit. Pegas 1 end 2
Depertment of Heelth es
Important: If Item 27 is
any injury or

Physician

Examiner

/Medical

Maryland 21215-0036

Baltimore,

6 Could not be determined

m.D

MD

29a. Certifier (Check only one)

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature end title of certifier

DU059107

LIBERTY

BALTIMORE

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Dete filed (Month, Day, Ye 2005 8

UMA, MID



DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 17 **Physician** Susan L. Kruchko June 2005 5:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Baltimore Gilchrist Ctr. Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Under 1, Day) | Min. | June 3, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 □ YF 219-44-3456 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits MD Baltimore Towson 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ar than "netural", or Items 23a or 731-A2 Camberley Circle 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married KRUCHKO, SUSAM 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ is marked other than Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Watson Clendaniel, Jr. Marguerite Sabo1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer K. Palestrant / daughter 316 Orchard Drive; Elizabeth City, NC 27909 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if itel
any injury or ott 1 Burial 2 Cremation 3 Removal from State ' 4 □ Donation Hilltop Service Corp. 6/20/05 Towson, MD 5 Other (Specify) 1050 York Road 22. Name and Address of Facility 21. Signature of Filmeral Service Licensee Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ignmil melmomA ear **Physician** mal /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 □ Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending investigation after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of dertifier 29c. License number 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md 21204 BINC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Robert E. Koehler, Sr. 17, 1:05 June 2005 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

August 8, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**∑**M 2□ F Director 345-09-7204 Yrs 84 Illinois Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ortant: If item 27 is marked other then "natural", or Items 23a or 28a-1 shov injury or other treumatic avent, the Medical Examinar must be notified at Directo Maryland 1 ☐ Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Cîtîzen of What Country? 3531 Tarkington Lane 20906 death United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 194 If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Ite 1 Never Married 2 Married 1944 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Marriott Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Finance 5+ Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Lawrence Koehler Martha Charlotte Marie Wartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma H. Koehler / Wife 3531 Tarkington Lane, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematory 20a. Method of Disposition 20c. Location - City or Town, State June Date 9, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 2005 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, (lagglefte Barnet MO1305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) WEEK /Medical Due to (or as a consequence of) ymphocytic Leukemick Examiner Aronic years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Box 68760, Physiclan/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. ☐ Yes 2☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2∏ No 1⊟ Yes 1 TYes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending after death. Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours To the Funaral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 54 Name and address of person who completed cause of death (Item 23a) (Type, Print ino 2010k mis 31. Date filed (Month, Day, Year) gistrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 16, Da 2005 **Physician** 12:18 PM LOMONOSOV LEONID /Medical 4c. County of Death 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CARROLL FINKSBURG 2002 DEER PARK ROAD If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month Day, Year APR. 11, 1937 9. Birthplace (State or Foreign Country) UKRAINE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Yrs. 68 Director 218-88-3663 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r then "natural", or Items 23e or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No CARROLL FINKSBURG MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2002 DEER PARK ROAD 21048 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) MECHANICAL ENGINEER ENGINEERING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental i (UNKNOWN) permit. Pages 1 and 2 should be Depertment of Health and Menta Importent: if Item 27 is marked any injury or other treumatic events. (UNKNOWN) BLUMIN TSAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 DEER PARK ROAD - FINKSBURG, MD 21048 MARINA SCHAUM / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/17/2005 OWINGS MILLS, MD HAR SINAI CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THRONIC OBSTRUCTURE PULMONARY Physician SYEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes ROMANY ARTERY disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No CHRONIC RENAL INSUFFICIENCY 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 x Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 Homicide ō To the Hospitel within 24 hours a To the Funerel C 29a. Cartifia Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

291 STOWER

031660

AVENUE WESTMINISTER

R. GOLUS TH

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

ma

THOMAS GAWW MA

20

31. Date filed (Month, Day, Year)

6/16/2005

MARYLAND 21157

			1 - For State Registrar	ate of Maryland / De C	epartment o Certificate o			giene 05	20355
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath	3. Time of Death
	/Media	cal	7	MYLES			JUNE	14,20	25 430KM
1	Examir	ner	4a. Facility Name (If not institution, give street NORTHWEST HO	SPITAL		n, or Location of		4c. County of E	Death IND E
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	(ay) If Under 1 Ye	ear If Under 24	Hrs. 8. Date of Bir	th 9.	Birthplace (State or Foreign
	Director		213-09-3407 18M	P□F 87 Yrs	Months Da	ys Hours	Min. (Month, Da 02 · 22	y, Year)	Birthplace (State or Foreign Country)
	and **		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				
	Many!	or	MD NIA	BALTIMO					10d. Inside City Limits 1 ►Yes 2 □ No
	r 28e	Director	10e. Street and Number	SALITIN	10f. Zip Coo	le		10g. Citizen of What	
	th will		3247 BELMONT AVI	ENUE	2	1216		USA	•
	r dea	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S. med Forces?	3. Was Decedent	of Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - A	American Indian, Vhite, etc.
36	rs afte	by Fi	If	JYes 2 MNo Yes, Give	1 ☐ Yes 2 🔼				
21215-0036	be filad within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28e-f show event, it a Marical Exeminer must be neithed at	ped to	15. Decedent's Education	ear or Dates:	ecedent's Usual Oc	cupation			BLACK
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Ē	Page nant c		1 MBurial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)				20/2005	Balla N	GN
Baltimore,	permit. Pagas 1 Department of H Importent: If Ite any injury or ot		21. Signature of Funeral Service Licensee	1 0	22. Name and Ad	dress of Facility	JAMES A	MORTO	ND Ursons F.H. IN
	₫ O E # 0		James U.1	Joten	1701 1	aure n	s St., BA	Ito, MD	21217
	*		23a. Patr. Enter the disease, or complication shock, or heart failure. List only one cau	s'that caused the death. Do not se on each line.	enter the mode of o	dying, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
7	Physician /Medical		resulting in death)		CARDIA	(IN	FARCTIC	DN	Onset and Death
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Box	death cartif e attending id for use as	clar	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	3 □Ectopic pregna 5 □ Other (specify)			23d. Date of o Month	Day Year
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Record	The law cate has b page 2 si	Completed					24a. Was a autops	an 24b. Were prior t	autopsy findings available o completion of cause of
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Vital		o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{Hospita} \)	l: 1 ☐ Inpatient 2 DER/Outpat	457.004	71h	Death (Check on or		
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jo	Vttendin death. ctor: Aft y the fun	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		/ork? □Yes 2□No			
Division of	I or Attending Ph after death. Director: After th i in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, offic	e	28f. Location (SI City or Town	treet and Number or	Rural Route Number,
	pital o		COO Continu			-			
	24 hos 24 hos Fun etely f	Medical	(Shock Shir) /2 Medical Exeminer; Of	To the best of my knowledge, denote basis of examination and/ord manner stated.	ath occurred at the investigation, in my	time, date and ply opinion, death o	lace, and due to the ca occurred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Me	29b. Signature and title of certifier		29c. Lice	nse number	2	9d. Date signed (Mo	nth, Day, Year)
C	1		1 Xon	/ MO	D	58932	3	JUNE 1	4,2005
1	1			cause of death (Item 23a) (Typ	e, Print)				*
\mathcal{C}			KERITH JOSE			OURT	RD RA	NOMUSTO	14, 2005 000 MD 2118
::	Stat Registra		31. Date filed (Month, Day, Year) JUN 2 0 2005	32 Registrar's Signature	ande				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Marie Martin /Medical 06 2005 1:15p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Retirement Community 709 Maiden Choice Lane Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 SAY 8. Date of Birth (Month, Day, Yea 1--07-1917 **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ F 217-05-7672 88 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. It would be considered at Director MD Baltimore 1 ☐ Yes 2 No Catonsville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 709 Maiden Choice Lane 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian filed within 72 hours after Black, White, etc. 1 Never Married 287 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Anna Mary Mueller ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robyn Martin/Granddaughter 1012 Queen Street Alexandria Va 22314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XDCremation 3 Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) view Crematory 6-20-2005 Baltimore, Maryland Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 gnature of Funeral Service 23a. Part l'Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebral accident Vascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Dysphagia leted 1 Yes 2 No 3 Probably 4 Punknown peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has Compl autopsy performed? certificate 1 ☐ Yes 2 10 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 5 Pending after death. Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44377 mos M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hoice Lane, Catensville, mp Deneen Bowlin , mn 711 Majden 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MIKROS Month Day Year **Physician** SOPHIE 19AV 11: /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Bayulew HOPKINS Care Center N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Director 220-12-6775 81 Feb. 22, Maryland Usual Residence of Decedent Pagas 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ent: If item 27 le marked other then "naturel", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinating the notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Baltimore Essex 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number LISA 8620 Kelso Drive 21221 Apt. D-202 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) В Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Skleres Ethel Vlanoas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Christine Mikros/Daughter 8701 Walther Blvd. Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. ' 4 □Donation 5 □ Other (Specify) Demetrios Cemetery 6/15/05 Outo Hill, Maryland St. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Touson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) uremia **Physician** /Medical Due to (or as a consequence of): Examiner renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: Tha law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 3 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Rart I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an (PSDICOL) certificate has autopsy performed malnutrition 2/2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 R/Outpatient 3 DOA Medical Certification: To 1 🗌 Yes this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident efter death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funerel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 h. To the Fun 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

State

5505

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bleeno.

B.

JUN 2

31. Date filed (Month, Day, Year)

William

DO4 383

Hopkins Bayview Circle

2005

Maryland

June

J. MII	나니반	State of Maryland 1- State Unpend Item 23a&27 per me G	/ Department of Health and N 84 ं श ामेंटेबर्सि ा किस्तान	Mental Hygie Reg.	
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
Physici /Medio		Betty Joann Miller		JUNE 1	7.2005 1057 A^{N}
Examir		4a. Facility Name (If not institution, give street and number) 86 TORQUE WAY	4b. City, Town, or Location of Death ESSEX		4c. County of Death BALTIMORE
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 13,	9. Birthplace (State or Foreig Country) 1934 North Carolina
		Usual Residence of Decedent	own or Location	Aug. 15,	10d. Inside City Limit
tha Marylan 286-f show	ctor	Maryland Baltimore	Middle River		1 ☐ Yes 2X No
or 28	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
s 23a	ra	86 Torque Way	21220	and Van and In	14. Race - American Indian,
72 nours attat daath with the Maryland natural', or Itams 23a or 28e-f show acal Examiner', uni be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ☼XNo Specify: 	Rican, etc.)	Black, White, etc. Specify: White
"natural",	eted	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16t	b. Kind of Business/Industry
iz should ba filed within a hand Mantal Hygiena. 7 la marked other than "I raumatic evant, Itte Mantal Mant	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Homemaker		Own Home
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nant o ant: If ary or		1 🗆 Burial 2013 Cremation 3 🗆 Hemoval from State	ew Crematory Inc 200		timore, Maryland
Parist. 1 ages 1 and 2 should be fined month of the Daparist of the Parist and Marial Hygiena. Important: If item 27 is marked other than "naturen yi jury or other traumatic evant, it was marked one.		21. Signature of Funeral Service Licansee	22. Name and Address of Facility Bru 1407 Old Eastern Av		
_		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Oo not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
ata ba axecutad physician and tha burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			
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w raquiras inat been signad b should ba data	by	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ (inknown
cartificata has been ractor, paga 2 should	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of steath? No 1 Yes 2 \subseteq No
actor,	Be	25. Was case referred to medical examiner?	Othor	h (Check only one)	
Aftar this funaral di	tion; To	X_J res 2 No 1 Inpatient 2 EH		me 5 Residence 28d. Describe how in	e 6 NOther <i>(Specify)</i> AT SCENE njury occurred
within 24 hours after death. To the Funantal Director: After completely filled in by the funa	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street City or Town, Si	t and Number or Rural Route Number, tate)
within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the	Me	29b. Signature and title of certifier	29c. License number OCME	29d. J U	Date signed (Month, Day, Year) NE 18, 2005
		30. Name and address of person who completed cause of death (Item 23		Baltimor	e, Maryland 21201
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		DOLUMNI	c, imiyimid 21201
Registr		HIN 2 0 2005	South !		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ALLEN L. MISTER, SR. Month Day June 15, 2005 12:20 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 23 East Randall St., Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 🖾 M 2 🗆 F 215-28-1395 72 Yrs. Director Jan 5, 1933 <u>Maryland</u> Usual Residence of Decedent the Maryland 10a. State al Hygiene.
I Hygiene.
I chiar than "natural", or items 23a or 28a-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/ABaltimore Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23 East Randall St., 21230 USA Funeral Let a. - UU36

wing 2 should be filed within 72 hours after design and Mental Hygiene.
27 is marked other *** 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. No Yes 2 No f Yes, Give f Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paint Co. Machine Operator permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If itam 27 is marked other ti any injury or other traumatic event, I'm 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Boone Brannan Elizabeth Mister ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Mister (Wife) 23 East Randall St., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 6/17/05 *4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee George M. Hampt on McCully-Polyniak Funeral Home, P.A. * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COPD /Medical Due to (or as a consequence of): Examiner noth A failure to thrive Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Tobacco dependence Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Thoselatran, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be lirector, page 2 s 24a. Was an autopsy performe 1 Yes 2√No 1 ☐ Yes 2 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 1 Tyes 2 / No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Mannut of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No М 2 Accident after death 6 Could to be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the hasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my or stated. 29a. Certifier Medical completely 2 Medic (Check only one) within 2 To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 000 60842 30. Name and address of person who complet (Item 23a) 1147 S. Hanover St., Baltimore, mp 21230 Iane 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar 2005

20360 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:45 AMM 2005 June 11 Dorothy Manolaros /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Genesis Hamilton Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Dec 5, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1□M 2♥F 82 Yrs Maryland Director 216-16-6780 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6040 Harford Road 21214 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ Il Hygiene. other than "naturel", 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9DRB. unk Be Nina Busch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Constance Blakely 5966 Glen Falls Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 🖫 Other (Specify) in state 21. Signature Fruneral Servic Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Diubele Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and doe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Onknown Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2∐ No After this certificature funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending To the musping after death, within 24 hours after death, To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 29a. Certifier 🏗 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 6/15 D31464 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

HOAIB

HASHMI MD

32. Registrar's Signature

&ZI N. EVTAN ST Smite 308 Balt. MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Neme (First, Middle, Last) Menth Yeer **Physician** 05:00 AM Tthe 2005 0 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day, Year)
July 20, 1958 5 noxBirthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days 4 1 ☐ M 2 🗸 F 21472-9095 Yrs Mary Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Marylend 10c. City, Town or Location 10b. County 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Maryles ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show ury or other traumatic event, the Medical Examinal must be notified at 1 Yes 2 □ No Director Mary land 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Street 21217 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College,(1-4or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Matthews Rogers Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Lip Code) 19a. Informant's Nag e/Relations ip (Type, Print) (Scn) Smith Batto. MO21217 VIVa 15 Lennox 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20d. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 3 Removal from State 1 Burial 2 □ Cremation King Memorial Yark June 23,2005 * 4 ☐ Donation 5 ☐ Other (Specify) neral Home, P.A. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility 2223 100) MD 21216 farres Tatelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chuce 26 mon 14 Lunc **Physician** mehomic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner to the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No certificate 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ NO Mesidence 6 ☐Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To his 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t 1 Watural 5 Pending investigation 2 🗆 No 1 Tyes within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 300Z

State Registrar

DHMH 17 Rev 1/2001

OBIGINIAL

3333 Nont Column

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

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Registrar's Signature

4/9/12

2005

Janes

31. Date filed (Month, Day, Year)

JUN

			1 - For State Registrer	State of Maryla				Mental Hyg		5 20362
	Physic /Medi		1. Decedent's Name (First, Middle, La Betty O'Donn	e11				2. Date of Death	Day Y	3. Time of Death
	Exami		4a. Facility Name (If not institution, git	spital	a land himbora.	BAL	r Location of Death	e	4c. County of	
	Funeral Director			1011 000	s. last birthday) 4 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 22	, 1920	9. Birthplace (State or Foreign Country) Ohio
	ith the Marylan or 28e-f ehow e rutified st	ector	MD 10a. State 10b. County	10c. C	City, Town or Lo	timore				10d. Inside City Limits 1 Yes 2 □ No
	th with the 23e or 2	Funeral Director	10e. Street and Number 5369 Cuthbert Av	venue #1		10f. Zip Code	215	10	g. Citizen of Wh	at Country? JSA
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "netural", or items 23e or 28e-f show other treumatic event, the Medical Evanticer must be notified at	b	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race -	American Indian, White, etc. White
1215-(within 72 h ene. then "netu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) unk	ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	sing	6b. Kind of Busin	ness/Industry
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, Inc. M.	To Be Co	17. Father's Name (First, Middle, Last	nk		caregive unk		e (First, Middle, M		aycare unk
	1 and 2 should I Health and Meni em 27 Is marker ther treumatic		19a. Informant's Name/Relationship (Valerie Johns		19b. Mailir 53	ng Address (Street) 69 Cuthbe	and Number or Run	a <i>l Route Number</i> , e #1 Balt	City or Town, Sta	ate, Zip Code) MD 21215
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Service Lice)	Removal from State	cemetery, crer	sition (Name of natory or other plac	(a)	Date 2	0c. Location - Cit	y or Town, State
Ba	permit. Departr Importe any inju		/www.	Hade Fire	St Ba	Name and Address ate Anato Itimore,	omy Board MD 2120	1		e Street
· · ·	Cate be executed hysician and hysician and physician and the burial-transit.	dical Examiner	23a. Part Enter the disease, or composed shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):		y, sucri as cardiac	or respiratory arres	SI,	Approximate Interval Between Onset and Death
0	the death certifi the attending ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
Δ.	sign d be	by	Part II. Other significant conditions o	ontributing to death but not re	sulting in the ur	derlying cause give	en in Part I.		_	te to the cause of death?
al Reco	The law ate has b page 2 s	e Completed	05 W					24a. Was an autopsy performe	ed? prior	
Division of Vital Records,	Phys this ral dii	ToB	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 Nursing Ho	n <i>(Check only one)</i> me 5 ☐ Residence 28d. Describe how	ce 6 □Other (5	Specify)
Divis	i o the Hospitel of Attanding within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,
	within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best of my knoiner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurr	and due to the caused at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
,	To To t	Σ	29b. Signature and title of certifier	125KI		29c. License			. Date signed (M	
			30. Name and addr ss of person who	completed cause of death (Iter	n 23a) (Type, F	Print)	000	D /	WIE S	2/215
i i	Sta Registr	7.6	31. Date filed (Month, Day, Year)	A Registrar's Sign	ature	NAI H	DSPITAL	UA / h	o.INJ	d1215

O'DOWNELL BETTY

2. Date of Death

The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending physician the signed by has certificate this After Director:

Month 75, 2885 NANCY **PAGANO** 1:30 P M 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Tawsan If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03-24-1914 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Funeral 1 □ M 2/CXF 212-32-9922 91 MÄRYLAND Director Usual Residence of Decedent should be filled within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or Items 23c or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at MD. LUTHERVILLE 1 Yes 2 10 BALTIMORE Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 909 MORRIS **AVENUE** 21093 U. S. A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 💢 💥 o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE β Specify XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YEARS College (1-4or 5+) OWN HOME HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Pages 1 and 2 should be nent of Health and Mental LAWRENCE LeGourd MARGARET TROTT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other tra JOAN A. POPE (DAUGHTER) 909 MORRIS AVENUE, LUTHERVILLE, MARYLAND, 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-18-2005 PARKVILLE, MARYLAND PARKWOOD CEMETERY 4 □Donation 5 □ Other (Specify) 1050 YORK ROAD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, INC. R. H. Kur (R.G.RUTH) TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HOURS CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of): YEARS CONGESTIVE CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) iner Exami YEARS CORONARY ARTERY DISEASE Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9∏ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🔽 No 3 ☐ Probably 4 ☐ Unknown FRACTURE LEFT HIP Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL INSUFFICIENCY autopsy performed? 1□ Yes 3√No 1 ☐ Yes 2/X/No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) XXYes 2 No 2 28d. Describe how injury occurred TURNETS IN HER KITCHEN, FELT FAINTS FELL 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: KITCHEN, FELT FAINTEFELL INSURING HER LEFT HIP 1 Natural 5 Pending 1 ☐ Yes 2√ No 2 Accident 3 ☐ Suicide investigation JUNE 11,2005 07:00 P^M 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 909 MCKRIS AVELUTHERVILLE, MD 21093 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 T Homicide HONE within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 15, 2005 D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 M. D. 76 32 Registrar's Signature 7601 OSLER DRIVE TOWSON, MARYLAND 21204 HELOU, ABDALLAH J. 31. Date filed (Month, Day, Year) State Sien It specie Registrar JUN 2 0 2005

DHMH 17 Rev 1/2001

		1 - For State Registrar	St	ate of	Marylar		artment rtificate			Mental Hyg	jiene eg. No.	2005	2036
Physic	ian	1. Decedent's Name (First, Middl Joseph Perico								2. Date of Dea Month	th Day	Year	3. Time of Death
/Medi Examir		4a. Facility Name (If not institution		and numb	1-0	4/	4b. City, To	own, or Loc	ation of Deat		4c. C	2005 County of Death	11
Funeral Director		5. Social Security Number 212–50–0453	<i>上げ合</i> 6. Sex 1気M			last birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs ours Min.	8. Date of Birth (Month, Day		Con	place (State or Foreigntry) Sylvania
ס	_	Usual Residence of Decedent 10a. State 10b. County				ty, Town or Lo				NOV 25	<u> </u>		10d. tnside City Limit
n the Mir 28e-f	Director	MD 10e. Street and Number			В	altimon	10f. Zip C	ode			0g. Citiz	en of What Cou	71
filed within 72 hours after death with the Maryland Hygione. sther than "natural", or items 23a or 28e-f show ent, the Medical Evantiner must be notified at	Funeral D	5927 Belair I 11. Marital Status 1 Never Married 2X Mar	12. V	rmed Forc ☐Yes 2				nt of Hispai y Cuban, M		pecify Yes or No- to Rican, etc.)	1	USA 4. Race - Ameri Black, White	
in 72 hours a "natural", o	Completed by	3 Widowed 4 Divorced 15. Deceder (Specify only highe	t's Educatio st grade con	npleted)		16a. Dece	1 ☐ Yes 25 dent's Usual kind of work DO NOT use	Occupation done durin	pecify: g most of wo	rking unk		Specify: wh: d of Business/Ir	ite ndustry un
be filed withital Hygiene.	Be	Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle,	unk Last)	College (1-4	or 5+)					ne (First, Middle,		Gumame)	
2 should be and Mental is marked c	2	Anthony D. Po				19b. Mailii	ng Address (Marie Hu Ural Route Numbe		Town, State, Zi	o Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene hours are selected to the than "natural; or items 23a or 28e-f show importent: if item 27 is marked other than "natural; or items 23a or 28e-f show amy injury or other treumstic event, the Mealical Enaminer must be notified at once.		Dorothy Peric 20a. Method of Disposition 1 Burial 2 Cremation 4 © Donation 5 Other (5	3 □Remo			5927 Place of Dispo cemetery, crea	sition (Name	of	ad Bal	timore, l		21206 ation - City or T	own, State
permit. P Departme importen any injury		21. Signature of Euneral Service ROTTal C		e/Dî			Name and Late Ai			d 655 W.	Balt	timore S	Street
Physician		23a. P. 11. Enter the disease, show, or heart failure. Littemmediate e (Final disease or condition	only one ca	use on eac	ch line.	th. Do not ent	ter the mode	of dying, su	ich as cardia			5	Approximate tnterval Between Onset and Death
/Medical Examiner	niner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S b	Due to (or	r as a consec	quence of):							
ate be execut hysician and the burial-trar	dical Examiner	that initiated events resulting in death) Last	c	Due to (or	r as a consec	quence of):							
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		Live bin	ome of pregn th 2 Feta nt at time of o	al death 3	⊒Ectopic preg ⊒ Other (<i>spe</i> c				23	3d. Date of deliv	ery Day Year
equires that en signed br ould be deta	by	Part II. Other significant conditi	ons contribu	iting to dea	th but not re	sulting in the u	inderlying cau	use given in	Part I.		bacco us		the cause of death? bably 4 Dunknow
iclen: The law ricerificate has be rector, page 2 sh	Completed										med? 21 X No	24b. Were autoprior to condeath? 1 Yes	opsy findings availab completion of cause of 2 No
g Physicler er this certif eral directo	n; To Be	25. Was case referred to medical examiner? 1 Tyes 2 Two 27. Manner of Death	Hosp 2	1 🗀 tnj	oatient 2 a Injury Day Year)	ER/Outpaties		Other		ath (Check only or Home 5 Resid 28d. Describe h	ence 6		fy)
To the Hospital or Attending Physiclen: The law within 24 hours effer death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	1 Actural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	gation not be	8e. Place o		Injury some, farm, st	М	1 🗌 Yes	2 🗌 No	28f. Location (S City or Tow		Number or Rui	al Route Number,
To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the th	edical Ce		Exeminer:		is of examin					, a, and due to the c urred at the time, c			
To th within To th compl	Me	29b. Signature and title of certific	1) (0)	an	MI	29c.	Doo:	mber 58/1	4/	19d. Date	signed (Month)	Day, Year)
		WENDIER.	DILL	AMS	MO	m 23a) (Type,	Print)	601 64K	LOCAMOR	H RAU	16N KYK	BOUL AND S	EVAR) 21339
St Regist	ate	31. Date fited (Month, Day, Year JUN 2 0	2005	32. Re	gistrar's Sign	ature	ster						

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 0 2005

32.

egistrar's Signatur

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

POVZHITKOV

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			For State Registrar	State of Mar		artment of F					
	• Physic		Decedent's Name (First, Middle, Last) NAUM			POVZHITKO		2. Date of Dea	Day	Year	3. Time of Death)
	/Medi Examir		4a. Facility Name (If not institution, give str			4b. City, Town, o	or Location of Death		4c. County		
*	Funeral Director		5. Social Security Number 6. Sex	OF BAL	In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day APR.14	h Y, Year) 1911		N/A place (State or Foreign http:// UKRAINE
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or L	ocation	-1-		,	1	0d. Inside City Limits
	the Maryland r 28e-f show	Director	MD BALTIM	ORE			BALTIMOR				1 □Yes 2 No
	th with t	al Dir	10e. Street and Number 16 OLD COURT ROAD	#218		10f. Zip Code	21208		10g. Citizen of		utry? USA
980	or items	by Funeral	11. Marital Status 12 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 🕅 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y:	
21215-0036	filed within 72 hours Hygiene ther than "netural" int, the Medical Ex	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occup a kind of work done DO NOT use retired	during most of world	king	16b. Kind of B		dustry
Maryland 2	e de la B	To Be C	17. Father's Name (First, Middle, Last) MENDEL		POVZHITKO		18. Mother's Nam	ne (First, Middle,		ne)	KNOWN)
	and and sm		19a. Informant's Name/Relationship (Type TONYA POVZHITKOV	•		ing Address (Street					
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tre		20a. Method of Disposition 1 ፟፟ Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cre		ce)	Date /2005	20c. Location -	City or To	
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	una	2	2. Name and Addre	ss of Facility SOL	LEVINSO	ON & BRO	os.,	INC.
	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the cause on each line.	e death. Do not en						Approximate Interval Between Onset and Death 3 months
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):						<u> </u>
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of):						
68760,	icate be executed physician and s the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a c	consequence of):						
P.O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	: If yes, outcome of 1 Live birth 2 1 4 Pregnant at tim	Fetal death 3	□Ectopic pregnancy	,		23d. Dai Mo	le of delive	ry Day Year
	w requires that the de been signed by the a should be detached f	by	Part II, Other significant conditions control Closhidium d	buting to death but r	. 1 .		en in Part I.				e cause of death?
al Records,	The taw ate has b page 2 sh	Completed						24a. Was a autops perform	med?	Were autoportor to condeath?	osy findings available npletion of cause of
of Vital	Physician: Th this certificate ral director, paç	To Be	25. Was case referred to medical examiner? 1 Tyes 2 Tyo	spital: 1 Impatient	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	h <i>Check only or</i> ome 5 ☐ Reside		er (Specify)
Division of	sing I. After fune	Medical Certification; 1	2 Accident investigation	28a. Date of Injury (Month, Day Yo		f 28c. Injur		28d. Describe ho			
Divi	al or Att s after d al Direct ed in by t	Sertifle	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rural	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medicel Exemine	ien: To the best of n r: On the basis of ex and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and ma late and place, a	nner as sta and due to	ited. the cause(s)
	To the vithir comp	Me	29b. Signature and title of certifier	// 11	ח	29c. License			9d. Date signed		
1	7		30. Name and address of person who com	pleted cause of deat			ENT 190				2005
1	-01		PRANITHA NAIN 31. Date filed (Month, Day, Year)	32. Registrar's		SINAL	HOSPITI	16 0.	FBA	L711	nore
	Sta Registr		JUN 2 0 201	- 3		nosti i					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:38 iel der 2005 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) County of Deat **Examiner** DURNIE NNEARLINDEL GLEN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1□M 2▼F Months Days Hours Min Yrs. Director 207-32-8496 Aug. 31, 1940 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28e-f show other treumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 2 **P**No Director Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1494 21122 U.S.A. Westcliff Drive items 23e Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 24. No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced is marked other than "neturei', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Hospital Registered Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Mental ant: If item 27 is marked o Donald Wilma George Whitebread ္က Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur E. Reider (Husband) 1494 Westcliff Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 6-17-05 Elkridge, Maryland ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122
Approximate 21. Signature of Funeral Service Licenses N 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nceshaloga **Physician** 10 week Ratic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ear Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attendion wherein and use as the burial-transit eavs terat Due to (or as a onsequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I λq 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No safter death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2001 ec to 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arunde JOYTH HOSA. 31. Date filed (Month, Day, Year) JUN 2 0 32 Registrar's Signature 2005

Registrar

	Physici /Medic		1- State Amend I Registrar amend i 1. Decedent's Name (First, Mid Allen Eu	gene Reynolo	per in ds	g846 -	-8/30/	U) JI	1	2. Date of De Month May 2	eath 23,200	05 Year	3. Time o	
	Examir		4a. Facility Name (If not institut Millennium He			ər	, ,	wm, or Loc estvi]	ation of Dea		4c.	County of Death		
	Funeral Director		5. Social Security Number 447–18–2114 Usual Residence of Decedent	6. Sex 7. 14☐ M 2☐ F	Age (In yrs. las	Yrs.	If Under 1 Months [Jnder 24 Hr ours Mir		nth ay, Ye <i>ar)</i> 7,192	Cou	place (Stete c intry) .ahoma	or Foreign
Maryland	a-f show	ctor	10a. State 10b. Coun	ecklenburg	10c. City,	Town or Lo		Char1	otte				10d. Inside C 1 X Yes	City Limits
with the	3a or 28 at be no	il Dire	10e. Street and Number 82 6306 7th Str	9 Plumstead	Road		10f. Zip Co	ode 28	3216 2001 1		10g. Citiz	en of What Cou USA	•	
5-0036 72 hours after death with the Maryland	artment of Health and Mental Hygiene. ortant: If item 27 Is marked other than "natural; or flems 23a or 28a-f show injury or other traumatic event, the Medical Exams entrust be rediffed at	by Funeral Director	11. Marital Status 1 Never Married 2 Marital Widowed 4 Divorce	12. Was Deceder Armed Force XXYes 2	es? □ No		Was Decedent If Yes, specify		nic Origin? (exican, Pue pecify:	Specify Yes or No to Rican, etc.)	1	4. Race - Amer Black, White	can Indian,	
d 21215-0036 filed within 72 hours af	iene. r than "natur I're Wedical	Completed		ent's Education nest grade completed)		(Give life.	dent's Usual C kind of work of DO NOT use stal Wo	done during retired)	g most of wo	orking		d of Business/Ir	,	nt.
land i	h and Mental Hygiene. 7 Is marked other than " traumatic event, I'm Mer	To Be C	17. Father's Name (First, Middle George W. Re	/				18.		me (First, Middle	, Maiden S		011111011	
_ ~	Health and Misem 27 Is man		19a. Informant's Name/Relation A. Tyrone McCar		w we	19b. Mailir 329 P.	ng Address (S lunsrea	ad Rd	Number or R	ural Route Numb arlotte,	er, City or NC 2	Town, State, Zi, 8216	o Code)	
Baltimore, bermit. Pages 1 ar	ent of Heant: If item	1	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 4 □ Dopetion 5 □ Other		20b. Plac		sition (Name natory or othe	of Hak	N,	Date Unk		ation - City or T		MD
Balt Permit	Department of h Important: if ite any injury or of		21. Signally e of Funeral Service			38	2. Name and A	Address of	Facility La	tney's I	Funer	al Home	, Inc.	
/	physician and Medical Manager the burial-transit	dical Examiner	23a. Part 1. Enter the disease, shock, of heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. — Parki Due to (or Hypen b. — Due to (or	inson's as a consequer tensive as a consequer as a consequer	Disea nce of): e Caro	ase						Approximation Interval Betto Onset and I	tween
Geath certifi	by the attending packed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal de it at time of deat	ath 3	Ectopic pregr Other (speci				23	d. Date of delive Month	,	Year
7 4	signed d be de	by	Part II. Other significant condi Hypertension		th but not resulting	ng in the ur	nderlying caus	se given in	Part I.		obacco us Yes 2	e contribute to t	he cause of do	_
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OT VICE Physician:	s certificat director, pa	o Be	25. Was case referred to medic examiner? 1 Yes 2XNo	Hospital:	ationt 2000	VOutpatien	2 7 004	Other		ath (Check only o		T0:: 10		
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5 8	after death Director: d in by the	ertification;	3 ☐ Suicide 6 ☐ Coul	mined 286. Place of	Injury - At home , etc. <i>(Specify)</i>	e, farm, stre	et, factory, of	ffice		28f. Location (S City or Tox		Number or Rura	l Route Numb	ber,
L ne Hospital	within 24 hours afte To the Funeral Dis completely filled in	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the be al Examiner: On the basi and manner	s of examination	dge, death and/or inv	occurred at the destigation, in	he time, da my opinion	ite and place , death occi	and due to the urred at the time,	cause(s) a date and p	nd manner as s lace, and due to	tated. the cause(s)	()
Tot	within 2 To the I	Me	29b. Signature and title of certif	ONICWO			Do	00553	14			signed (Month, 27, 2005	Day, Year)	
		-	39 Name and address of perso		of death (Item 23		1			-				Nd

			1 - State of Maryland /		artment of Health and M rtificate of Death		ene, g. No. 005	20369
	Physici /Medic		Decedent's Name (First, Middle, Last) RONALD TAYLO	R S	HARPE, SR	2. Date of Death Month 6	Day Year 15 2005	
	Examin		4a. Facility Name (If not institution, give street and number) Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last	hirthday)	4b. City, Town, or Location of Death Balto If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Dea	
200	Funeral Director		094-30-7737	Yrs.	Months Days Hours Min.	(Month, Day, 9-6-19	Year) 9.86 938	rthplace (State or Foreign ountry) N • Y •
	ъв Marylan 8a-f show	Director		alto				10d. Inside City Limits X☐ Yes 2☐ No
	with the Sc or 2		10e. Street and Number 5421 Fairlawn Avenue		10f. Zip Code 21215	10	g. Citizen of What C USA	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23s or 28s-f show or other treumatic event, the Medical Examination in the field of the contractions.	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		ZTZT3 Was Decedent of Hispanic Origin? (Speid Yes, specify Cuban, Mexican, Puerto 1□ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	te, etc.
Baltimore, Maryland 21215-0036	e filed within 72 horal Hygiene." nature	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade N/A	(Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) f	ng	6b. Kind of Business Restaurant	,
yland	should be filed and Mental Hygies as marked other umatic event, the	To Be C	17. Father's Name (First, Middle, Last) John Sharpe, Sr		18. Mother's Name Virginia	Sharpe		
Ma	is 1 and 2 sho of Health and item 27 is ma other treum				ng Address <i>(Street and Number or Rura</i> Fairlawn Avenue			Zip Code)
imore,	permit. Pages 1 and Department of Heali Importent: If item 2 eny injury or other once.		PED DUTA 2 DOTAINATION 3 DINATION State		sition (Name of natory or other place) prial Park 6-20-		Oc. Location - City or	
Balt	permit. Depart Import eny inj		21. Signature of Fundral Service Licensee		4300 Wabash A		West Balto, Md	21215
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	S 20 of): 15 d	er the mode of dying, such as cardiac of		st,	Approximate Interval Between Onset and Death
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rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause given in Part I.			o the cause of death?
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	To the Hospitel or within 24 hours after to the Funeral Director completely filled in I	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled 2 Medicel Exeminer: On the basis of examination and manner stated.	ige, death and/or inv	estigation, in my opinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
,	So T Will	Σ	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Mont	h. Day, Year)
	6		30. Napre and address of person who completed cause of death (Item 23a	(Type, I			1/0/10	
*-a	Sta	te	31. Date filed (Month, Pay, Year) 0 2005 32. Jegistrar's Signature	5 f	CHEEN IKE	PRD	PIKE	JULE, M
35	Registra		JUN & U ZUUD JAROUEN JO	19	ALY THE			

			1- For State of Maryland / Dep Registrar	artment of Health		_	gien Reg. No	21115	20370
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of De		ay Year	3. Time of Death
	/Medic		Ione Sanders			June 1	9,	2005	10:45 M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 19 Admiral Blvd.	4b. City, Town, or Locatio Dundalk	on of Death		40	c. County of Dea Baltimo	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		der 24 Hrs.	P. Data of Bir	*ba		
	Funeral Director		214-07-0744 1 M 2 XF 91 Yrs.	Months Days Hours	rs Min.	8. Date of Bir June 2	9 Year	1913	thplace (State or Foreign ountry)
	ס		Usual Residence of Decedent					, , , , , , , , , , , , , , , , , , ,	ac.
	anylar show	_	10a. State 10b. County 10c. City, Town or L Md. Baltimore Dunda						10d. Inside City Limits
	Ba-f	acto							1 ☐ Yes 2 🛣 No
	within 72 hours after death with fine Maryland ene. then *netural', or items 23e or 28e-f show the Medical Exertiner mast be notified at	Funeral Director	19 Admiral Blvd.	10f. Zip Code				itizen of What C	ountry?
	eath	erai		Was Decedent of Hispania	Origin? (Spec	oifu Van ar Na	USZ	A 14. Race - Amo	oriona Indian
· _	r Iten	E	Armed Forces?	Was Decedent of Hispanic Of Yes, specify Cuban, Mexic	can, Puerto P	lican, etc.)		Black, Whi	te, etc.
ဗ္ဗ	ours a	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specia	eify:			Specify: V	White
2	72 hc	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	nost of workin	a	16b. F	Kind of Business	VIndustry
2	hen.	шb	Elementary/Secondary (U-12) College (1-4or 5+)	e kind of work done during m DO NOT use retired)		9			
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and	be d is b	Be c	George Loy		lamie	Loy	Maidel	n Surname;	
Maryland 21215-0036	is 1 and 2 should of Health and Menitem 27 is marke other traumatic	ဥ		ing Address (Street and Num			er. City	or Town, State.	Zip Code)
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č,	es 1 a of Hea fitem r othe		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	June	ite		ocation - City or	Town, State
Ĕ	Pages nenf of ant: If it ury or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	idgé Cemi.		005	Elk	cridge	
Baltimore,	permit. Page Department Important: II any Injury o		21. Signature of Funeral Service 1 coacea	2. Name and Address of Factionnelly Fune	cility ral Ho	me of i	Dund	Ralk	
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	Physician /Medical Examiner	Examiner	23a. Parl 1. Enter the disease, or complications that ceused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or nijng y	yleger	w_	Leu	ki	Mie	Approximate Interval Between Onset and Death
3/60,	cate be executed obysician and the burial-transit	dicai Exan	that initiated events resulting in death) Last c. Due to (or as a consequence of):						
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C. Box	requires that the death certifics een signed by the attending ph nould be detached for use as t	Physician/Me		□Ectopic pregnancy □ Other (specify)				23d. Date of dei Month	livery Day Year
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r	icien: The law re certificate has bee rector, page 2 sho	Completed						prior to death?	utopsy findings available completion of cause of
VItal	ysician: is certific director,	Be (25. Was case referred to medical examiner?	26. Pla	ace of Death	Check only o			
0 0	G is X	٥	1 ☐ Yes 2 💢 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 D	Nursing Hom	e 5XX Resid	dence	6 □Other (Spe	cify)
Ē	ding Ph After th funeral	i o	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28	ld. Describe h			
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2	al or Attending F s after death. It Director: After ed in by the funera	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	еет, тастогу, опісе	20	City or Tow	m, State	na Number or Hu e)	ural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Checker of the control of the cont	h occurred at the time, date a	and place, an	d due to the o	cause(s)) and manner as d place, and due	stated.
	o the ithin 2 o the omple	Med	one and manner stated. 29b Signature and title of certifier	29c. License number				te signed (Monti	
	F 3 F 8		Jan Olden	D00 10	P64	10	00	1/2e/	01
	10		30. Not end address of person who completed cause of death (Item 23a) (Type, Louis O.OLS EN MO - 2£25 Louis O.OLS EN MO -	NGE FALLI	(s)-	DAL	N.	Mel	21219
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0 2005 32 Registrar's Signature	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Gladys Scheler B. 06 12:44 -2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Franklin Sq. uare Hospital
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Baltimore 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1 □ M 200 Months 219-14-2002 82 Director November 3,1922 MD. Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location item 27 is marked other than "naturel", or items 23s or 28e-f show other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MD. Baltimore Director Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10400 Bird River Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 years Sales person Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas S. Bacon Margaret Cowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Joyce Goettzinger 10400 Bird River Road, Essex, Md. 21220 sister Baltimore, If item 20b. Place of Disposition (Name of cemetery, crematory or other place) June 21, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) injury or permit. Page Department of Importent: If any injury or once. Oak Lawn Cemetery 2005 Dundalk, MD 21. Signatore of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lute Dysrhythmia
Due to (or as a consequence of): Acute disease or condition resulting in death) /Medical Examiner Probable pulmonary embolus 315 Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-tran that initiated events Windhar Due to (or as a consequence of) ON APPROVED BY resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical CERTIFICA IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has (ORI perform Fine fracture yes Recent repair 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death Check on one Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After thi Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) 5 Pending investigation doloral 6-3-2005 unknown M subject fell 1 ☐ Yes 2 🗷 No 2 X Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office
Assisted Living apartment hallway 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide 1320 Windless Dr. Middle River 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MAD 03 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Dr. Kevin Smothers Square Drive, Baltimore, MD 21237

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 2 0 2005

0)

Franklin

. Registrar's Signature

			State of Maryland / Dep 1- State Registrar amend item #25 per fh g849		Mental Hygier	0.0
	Physic		1. Decedent's Name (First, Middle, Last) Rayeld Smith	. 0/20/05 01	2. Date of Death	Day Year 3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give street and number) S. 'was' Hosp.' fall	4b. City, Town, or Location of Death Baltimore		4c. County of Death Bultimore City
	Funeral Director		5. Social Security Number Company 1 Security Number 1 Security Num	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 2/13/196	9. Birthplace (State or Foreign Country) Washington DC
	death with the Maryland rms 23s or 28e-f show	or	Usual Residence of Decedent	coation Halethorpe		10d. Inside City Limits 1 ☐ Yes 2 🏹 No
	or 28e-	Director	10e. Street and Number	10f. Zip Code		Ditizen of What Country?
	ms 236	Funerai	1908 Woodside Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp.		Inited States 14. Race - American Indian,
	or Ite	þ	Armed Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ene. than "naf	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use tetired) ECCY Medical Technician	ing	Kind of Business/Industry [ealthcare
nd 2	othe	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
ryla	Mer Mer atic	2	James Edward Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailii	Anna S		T. 0. T. 0.11
	od 2 s Ith ar 27 is r trau	8		ng Address <i>(Street and Number or Rura</i> Woodside Avenue,		
Baltimore,	iges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Dispo	position (Name of pratesy or other place)		Location - City or Town, State
altim	t. Pa rtmer rtant		4 Donation 5 Other (Specify) Memorial 21. Signature Fundament Service Donate 22.	Park 6-17 2. Name and Address of Facility Am		kridge, MD
B	Depa Impo any ic	7		328 Sulphur Spring		
1	Inysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	for the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode o		Approximate Interval Between Onset and Death
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause it any leading to immediate cause it all the manage cause (Disease or injury			
90,	be executed ician and burial-transi		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	tificate be er ig physician as the buria	edicai	d			
P.O. Box	ne death cer the attendin hed for use	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that the second of	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 2 No
Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? Hospital: 1 □ Inpatient 2 X=R/Outpatien	26. Place of Death		
	ing Phys After this Ineral di		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending	28c. Injury at Work?	ne 5 🗌 Residence 28d. Describe how inj	
Division	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After I completely filled in by the funerel	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, str	M 1 ☐ Yes 2 X No eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	e Hospitel 24 hours a Funerel etely filled	Medicai Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(and at the time, date an	s) and manner as stated. Individual states of the cause (s)
,	within To th comp	Me	29b. Signature and title of confitier	29c, License number DO05702	99 29d. D	ate signed (Month, Day, Year) 6/14/2005
	6		29b. Signature and title of califier 30. Name and address of person who completed cause of death (Item 23a) (Type 1 3 3 8 6 7 2 4 4 5 6 7 6 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7	Print) of 535 f	ikesvil	1/e, mo 21208
	Sta Registr	te	31. Date filed (Month, Day, Year) JUN 2 0 2005 32. Registrar's Signature	U		

The property from the Three Minds (ass) South of Dames True (Minds) (ass) A STATE SECRET SE	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	5 20373
Summer Figure Summer S	Decedent's Name (First, Middle, Last) 2. Date of Death	
# Pasish Name (if not existion of users an unknown) # Court of Castern Visited Castern Vis	INSERULT KACERS SIANA WAR 14 1	005 1245 PM
Social Security Numbers Size Si	Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of	
The state of designed of the state of the state o		
Description of the property of	Funeral	Country)
The part of the pa	Usual Residence of Decedent	CUT A CAROLINA
The part of the pa	10a. State 10b. County 10c. City, Town or Location	
The part of the pa	MARYLAND BALTIMORE CATONSVILLE	1 L Yes 2 X No
The part of the pa	10g. Citizen of W	at Country?
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The part of the pa	Specify: Sp	BLACK
The part of the pa	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Specify only highest grade completed) (Specify only highest grade completed)	ness/Industry
The part of the pa	College (1-4or 5+)	10 0-
19 19 19 19 19 19 19 19	N The IS	
198. Informants Name-Relationship (Type, Print) 199. Mailing Address (Sinet and Number or Rural Rouse Number, City or Town, State, Ze Code) N I Co L E ROGER (SRADDEKSHER) 199. A PALTO HO Co Town, State 2 Location - City or Town,	a garage and description of the state of the	
20. Method of Disposition Will be a seried of the Disposition Will be a seried of t	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S	
A Contains S Committee	NICOLE ROGERSGRANDDAUGHTER) 7417 LESADA DR APTZA BALTO,	MO 21244
21. Signature of Report Space Licenses 22. Name and Address of Figurity 2 140 North Futton Andrews 22. Name and Address of Figurity 2 140 North Futton Andress 22. Name and Address of Figurity 2 140 North Futton Andress 22. Name and Address of Figurity 2 140 North Futton Andress 22. Name and Address of Figurity 2 140 North Futton Andress 22. Name and Address of Figurity 2 140 North Futton Andress 22. Name and Address of Figurity 2 140 North Futton 22. Name and Address of Figurity 2 140 North Futton Andres 22.	20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 20c. Location - (Commetery, crematory or other place)	ity or Town, State
Physician (Medical Examiner) 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause of Bullium. List only one cause on such the cause of the such and place in the such and place in the such		5 MARYLAND
Physician (Medical Examiner) 23.2 Part i. Einer the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, immediate Cause (Final Interval Between Chast and Palar) 14. Control of palar in the cast is conditions, cause, cardiac or respiratory arrest, interval Between Chast and Palar interval Betw		
Physician Medical Examiner Physician Medical Examiner	Joseph H. Drown, Jr. Funeral Ho.	
Macellical Examiner Macellical Examiner	shock, or heart failure. List only one cause on eagh line.	Interval Between
Sequentially list conditions, a any leading to mendate datase. Enter funderlying Cause (Disease or Injury that mittade design of the death) Last Part P	disease or condition disease or condition a. 71 (ULL NOTICE TO THE CONTROL THE CONTROL TO THE CONTROL TO THE CONTROL TO THE CONTROL TO THE CO	
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Due to (or as a consequence of): Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying	
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The state of Death The sta	O we set to be defined?	re autopsy findings available or to completion of cause of ath?
Property of the state of the st	To yes 2 10 1 25 Was rase referred to medical 25 Was rase referred to which we was referred to medical 25 Was rase referred to which we was referred to which we was referred to which we was referred to which we was referred to which we was referred to which we was referred to which we was referred to which we was referred to which we was referred t	Yes 2 No
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	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravon Blue 353 Bulton	w21238
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature		

			1 - For State Registrar	State of M	arylan		artment of F rtificate of		nd M		giene Reg. No.	15	20374
п	Physic	ion	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		Jack C.	Shaw						4	- 15-	05	6:35+M
	Exami	ner	4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of	Death		4c. Cou	nty of Death)
			Hanklin Square >	Juspital Cen	KC		Prosedal	e			Ba	timor	· ·
	Funeral		5. Social Security Number	. Sex 7. Ag 1X M 2 ☐ F	e (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da	th v Year)		place (State or Foreign intry)
	Director		181-18-9507	12M 2UF	83	Yrs.	Working Days	riodis	IVIII I.	5/1/19	22	Peni	nsylvania
	pur *		Usual Residence of Decedent 10a. State 10b. County		100 Cib	, Town or Lo							
	sho	5	Too. County		100. 0119	, TOWNTON LC	Cation						10d. Inside City Limits
	he h	ect	Maryland Baltin	ore	Ess	ex							1 ☐ Yes 2 📉 No
	with or s	ä	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?
	s 23	Fra	714 N. Woodward		=	-	21221				U.S.		
	er de	L L	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Spec Puerto F	cify Yes or No lican, etc.)	- 14. A	ace - Ameri lack, White	
36	rs aft	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:	194	3	1□Yes 2XINo	Specify:			Spe	cify:	
5-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show areal Examirat roust be rodified at	ed !	15. Decedent's		198		dent's Usual Occup	ation			105 105 106		ite
215	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done	durina most i	of workin	g	16b. Kind of	Business/ir	ndustry
212	iene. r than "	E	Elementary/Secondary (0-12)	College (1-4or t	5+)		ing Offic	,			Natio	പെ വ	12rd
	Hygi other ent.	BeC	17. Father's Name (First, Middle, La	st)		TEGE	ing orri		's Name	(First, Middle,			aaru
an	ould be filed with Mental Hygiene. arkad other than atic avent. The M	To B	Russell E. Shaw				The state of the s			. Henr		,	
Maryland	2 should and Men Is marka	-	19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailir	ng Address (Street					m State Zii	n Code)
	nd 2 alth a 27 ls		Ruth Shaw (Wife)				. Woodwa						
ē,	s 1 a f Hea item othe		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Pl	ace of Dispo	sition (Name of		Da	ate	20c. Location		
J.	age ent o et: If y or		1 Burial 2 Cremation 3	☐Removal from State	_		natory`or other plac	_1	_ 6	720 005	D. 1 3		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other treumatic avent. The Marical Examiner must be notified at ance.		21. Signature of Funeral Service Lie		BeT		Memorial (_			Bet A:	ır, Ma	aryland
B	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tre <u>once</u> .	1	1/15/11			Br 17	Name and Address UZdzinsk 07 Old Ea	i Fune	ral	Home P	A CCOY N	م [تعمد م	nd 21221
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o o	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as									
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68	tificate ig phys as the										-		
ŏ	eath certiff attending for use as	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			le				23d. D	ate of delive	ery
m	deat e attr	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other <i>(specify)</i>				N	lonth	Day Year
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rd	w require been się should b									1 □ Y	es 2 No	3 Prob	abiy 4 Unknown
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>	S 0 75	O B	examiner? 1 Tes 2 No	Hospital:	nt 2□E	R/Outpatien	3 DOA Othe	25		e 5 Resid		her /Snecifi	w)
	g Phy er thi	T:U	27. Manner of Death	28a. Date of Injur	у :	28b. Time of	28c. Injury Work			d. Describe h			77
0	Attending F r death. ector: After by the funer.	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	on (Month, Day	1901)	Injury		r Yes 2 □ No	,				
Division	of or Attence after death Director:	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ıry · At hon	ne, farm, stre	et, factory, office		28	f. Location (S	treet and Num	ber or Rura	I Route Number,
Ö	tel or s afte el Dir	Certification;		building, etc	. (Specify)					City or Tow	n, State)		
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at the timestigation, in my op	e, date and pointion, death	place, an	d due to the c I at the time, d	ause(s) and n ate and place	anner as st	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	00			29c. License	number		2	9d. Date sign	ed (Month,	Day, Year)
	*		1		a A A		053	694			61	16/10	5
	1 X		30. Name and address of person wh	Completed cause of de	ath /Item	23a) (Type 1		. , ,			0]	0,0	
	6	- 3	Dr. Daniel Shinn	ex 9000 F	anKI	a Sex	Print) Lare Drive	Bul	h'man	7 HIA	2173	7	
	Sta	te	31. Date filed (Month, Day, Year)	3 Registra	ir's Signatu	ire .	UI C DI IVE	Luci)	11761	4 190	-120	/	
	Registr		JUN 2 0 20	105 June	, di	Apo	de						

		•	For State Registrar	State of	of Marylar		artment of H		Mental Hyg	giene Reg. No:)5	20375
	Physicia	an	1. Decedent's Name (First, Midd MARY AGN		IVERS				2. Date of Dea Month JUNE 1		Year	3. Time of Death 4:05 p M
	/Medic Examin	al	4a. Facility Name (If not institution 607 ELIOT				4b. City, Town, or PASADE			4c. County		
	Funeral Director		5. Social Security Number 213–34–8947	6. Sex 1 □ M 2 1 F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		5	9. Birth	place (State or Foreign intry) land
	מ	-	Usual Residence of Decedent 10a, State 10b, County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Maryiz II sho	to		Arunde1		Pa	sadena					1 Yes 2 No
	ith the or 28a	Director	10e. Street and Number	ul.			10f. Zip Code			10g. Citizen of V		intry?
	s 23a	srai [607 Eliot Roa		cedent Ever in U	19 13	211		Specify Yes or No-		A. e - Ameri	ican Indian,
336	within 72 hours after death with the Maryland fene. I than "naturel", or items 23a or 28a-f show I the Madical Examinar must be mailfied at	by Funerai	11. Marital Status 1 Never Married 2 Mai 3 Will Wildowed 4 Divorce	nied Armed F	orces? 2 12 No live		f Yes, specify Cuba 1 ☐ Yes 2 🗹 No	Specify:	rto Rican, etc.)		ck, White	
2-0	72 hou		15. Decede (Specify only highe	nt's Education est grade completed)	16a. Dece	dent's Usual Occup	ation during most of w	orking	16b. Kind of B	usiness/li	ndustry
Maryland 21215-0036	within ene.	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	1	<i>do not usa ratira</i> d Homemaker	•		Нс	me	
d 2	il Hyg other	Be Co	17. Father's Name (First, Middle						ame (First, Middle,		n e)	
ylar	D & 3 O	10 5	Charles J.	White		105 14-10		Mary	V.Charl	_	State 7	in Code)
Mar	12 ha		19a. Informant's Name/Relation Rose Jordan	onip (<i>Type, Print)</i> (Daughte	er)		•		den, Mary			p 000e)
ore,	of He	1	20a. Method of Disposition 1 ØBurial 2 ☐ Cremation		20b.	Place of Dispo	esition (Name of matory or other place		Date	20c. Location -		own, State
Baltimore,	Pages Iment of tant: If it jury or o		`4 □Donation 5 □Other (Specify)	Me	-	dge Mem F		18-05	Elkride	ge, M	Maryland
Balt	permit. Page Department Important: II any injury or		21. Signature of Fun val Service	8 Kour	nul	\int 3		olyniak ain Roa	funeral d, Pasade		A ylan	
П			23a. art1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the dea each line.	th. Do not en	er the mode of dyir	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sue	o (or as a conse	quence of):			-			sweeks
ì	Examiner		Sequentially list conditions	b. 03	teom	nelit	3				_	Bosouth
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conse	opence of):						month
,	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	C. Due to	o (das a conse	quence of):	1.6	" O				40.
8760,	ate be hysicia he bur	dicai		(d. 1/2	r, feu	al 1	Arteri	il Ul	sear			lears
.O. Box 68	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregrebith 2 Felgnant at time of	tal death 3	Ectopic pregnancy	y			te of deliventh	very Day Year
<u>α</u>	uires that th signed by Id be detac	þ	Part II. Other significant condit	ions contributing to		esulting in the u	inderlying cause giv	ven in Part I.	23e. Did to			the cause of death?
Records,	The law requir ite has been si bage 2 should l	Completed	Congestu	ie Heav	t Fu	ilue	2			rmed	Were aut prior to c death? 1 Yes	topsy findings available completion of cause of
Vital	ding Physiclen: The Interpretation of the The After this certificate had funeral director, page	Be	25. Was case referred to medic examiner?	Hospital:			Ott		eath (Check only o			
of	Physi r this o	. To	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time o	nt 3L DOA	4 Nursing	Home 5 Resident	dence 6 ∐Oth now injury occur		ify)
ion	Attending I rr death. ector: After by the funer	atlor	Z Accident	tigation	onth, Day Year)	Injury		rk? Yes 2 □No				
Division	l or Attener after death Director:	ertific	3 Suicide 6 Could 4 Homicide deter	minod 200. Pid	ce of Injury - At Iding, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (: City or Tox		ber or Ru	ral Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification;	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physicien: To t Il Exeminer: On the and ma	he best of my ki basis of examination	nowledge, deal nation and/or in	th occurred at the ti nvestigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
)	To th Withir To th	Me	29b. Signature and title of certif	· Hom	ren 1	no	29c. Licens	23811	1	29dy Date signe	00	5
	10		30. Name and address of person Jenathah Fo	who completed ca	use of death (It	em 23a) (Type 1 66 B	S-Crain	304	Glen Bu	This p	10 1	1061
	St Regist	ate rar	31. Date filed (Month, Pay Yea	0 2005	Pegistrar's Sig	nature	parke					

			1 - For State Registrar	State of M	arylan		artment rtificate				ental Hy	giene	4 U U 5	203	76
ı	Physici		Decedent's Name (First, Middle, La	Bua Dit	ta Sh	arma					2. Date of De Month June	aath		3. Time of 5:15	Death P M
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location (of Death	bane	- 3	County of Death		
	LAGIIII		2106 Queensguard						Spr				lontgome		
	Funeral		Social Security Number 6. S		ge (In yrs. I	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	rth	9 Birth	place (State or intry)	r Foreign
	Director		216-96-4268	IXM 2□F	85	Yrs.	Months	Days	Hours	Min.	Jan. 26	5 , Year)	20 In	dia	
	pu ,		Usual Residence of Decedent		1										
	anyla shov	-	10a. State 10b. County		10c. City	, Town or Lo								10d. Inside Cit	-
	Ba-f	ecto	Maryland Montgo	mery		Silve	r Spr							1 🗌 Yes	2 KI No
	with t	Ö	10e. Street and Number	D 1			10f. Zip					10g. Citi	izen of What Cou	intry?	
	eath	eral	2106 Queensguard		Francis III	C 140 1	Man Desert		0906	. 0.10	" "		ted Sta		
	be tiled within 72 hours after death with the Maryland tal Hygiene d other than "natural", or Items 23a or 28a-f show avent, The Medical Examinat must be invitited at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	,	5. 13.1	f Yes, spec	ent of His fy Cubar	spanic Ori n, Mexicar	gin? (Spec n, Puerto F	cify Yes or No Rican, etc.))-	 Race - Amer Black, White 		
21215-0036	urs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	140		1 ☐ Yes 2	⊠ No	Specify:				Specify: A c	ian-Ind	lian
Ŏ	2 hou	ted	15. Decedent's Ed			16a. Deced	dent's Usual	Occupa	ition			16b. Ki	nd of Business/li		. Lall
2	hin 7	ble	(Specify only highest gra	college (1-4or)	5.4)	(Give life. L	kind of worl DO NOT use	k done d e retired)	luring mos.)	t of workin	ng .			,,,,,,	
2	giene giene er th	Completed	12	College (1-40)	3+)	Insp	ector					Cen	tral Gov	ernmen	t
5	al Hy l othe	Be (17. Father's Name (First, Middle, Last,)					18. Mothe	er's Name	(First, Middle	Maiden	Sumame)		
<u>Ja</u>	Ment Ment	Tol	Bal Mukund						Mat	thura	Devi				
Maryland	2 sho and Is mu		19a. Informant's Name/Relationship (**									r Town, State, Zi		
2	and ealth m 27		Sushil Sharma/Son		- 1				rd Ro			Spri	ng, Mary	1and 20	906
0	ges 1 t of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	Mon	lace of Dispo- emetery, cren LEGOME1	sition (Nam natory or oth	e of her place	9)	June	1 Q	20c. Lo	cation - City or T	own, State	
Ē	tant:		`4 ☐ Donation 5 ☐ Other (Specify	y)	Cre	emator.	ium,	Lnc.	1	200	5		nesda, M		
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.		21. Signature of Funeral Service Licer		M0019	98 Rô	bert 7 Wisc	A. P cons	s of Facilit umphi in Av	rey F	uneral ethesd	Home	e/ ^{Bethes} Chase D 20814-	da-Che Inc. 3501	vy
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death	. Do not ente	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	Met	astat	tic Li	ver Ca	ance	r					Onset and D Months	
	/Medical Examiner		resulting in death)	Due to (or as										nonchs	
	LXamilie	.	Sequentially list conditions,	b											
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/ _^	axecu al-tra	Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ience of):									
8760	icate be executed physician and s the burial-transit	dical		d											
89		edic		u											
Box	death certific e attending p id for use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnar		IF					2	3d. Date of deliv	ery	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Ectopic pre Other (spe						Month	Day Ye	ear
о. О	at the de I by the a stached I	Physician/Me	9 Unknown									i			
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of Renal Cell Cap		ut not resu	Iting in the un	iderlying cai	use givei	n in Part I.				se contribute to t		
ecords,	w require been si should?	Completed		CITOMA							101	/es 212	No 3 Prob	oably 4 Ur	iknown
ec	e law has b	nple									24a. Was autop	sv	24b. Were auto	psy findings av	vailable use of
	Th ate pag	S										rmed? 2 <mark>☑</mark> No	death?		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o				
ō	Phys this ral dii	L.	1 ☐ Yes 2 XNo 27. Manner of Death	1 Inpatie		ER/Outpatient 28b. Time of		Other c. Injury	4 🗆 IVUI				□Other (Specif	y)	
o	ding h. Atter tuner	tion	1 XNatural 5 ☐ Pending	(Month, Day	Year)	Injury	M	Work?	at } es 2.⊟N		3d. Describe h	iow injury	occurred		
Division	l or Attendi after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be		ury - At hor	me, farm, stre			00 2 2.		3f. Location (S	Street and	l Number or Rura	l Route Numbe	er
á	spital or A ours after ieral Directified in by	Certification:	4 Homicide	building, etc			,,				City or Ton	m, State)			.,
	1 1 1 1 1	edical (29a. Certifier 1⊠ Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred at estigation, ii	the time	o, date and nion, deat	d place, an	d due to the d	cause(s) a	and manner as s place, and due to	tated. the cause(s)	
	To the I within 2. To the I complet	Me	29b. Signature and little of certifier				29c.	License	number			29d. Date	signed (Month,	Day, Year)	
			I Chile as	ne				BR.42	1611	4		June	19, 200)5	
	1		30. Name and address of person												
	Q		Chitra Rajagopal,	M.D. 181	111 P	rince	Phili	p Dr	ive,	01ne	y, Mar	y1an	d 20832		
	Sta Registra	-0.0	31. Date filed (Month, Day, Year) JUN 2 0	32. Registra 2005	ar's Signati د مرجور	B A	poole	,							

amend item#25, Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** June 13, Marv Lee Patricia Tumminello 3:05 □ м /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Tausan Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) 5. Social Security Number 6. Sax 9. Birthplace (State or Foreign 1 □ M 2 🔽 F 220-12-9378 Marvland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2☑ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Old Harford Road #211 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Cullender 0 Alice Velenowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Friesner-daughter 70 Montvieu Ct., Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem'l Gard 6/17/05 * 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service License William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Tawson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 minutes Due to (or as a consequence of): ear S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or onsequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown NA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart 1 Yes 2 No 3 Probably 4 DUnknown * Sol 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? cinemia 1 ☐ Yes 2 **□+**√0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? ice of Death (Check only one) Hospital: 1 I patient 2 ER/Outpatient 3 DOA Other 1 X Yes 2 → We-4 ☐ Nursing Home 28b. Time of Un 28c. Injury at Work? 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

Priysician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

 $\alpha' \delta D$ Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2::
Department of Health ar
Important: If item 27 is
any injury or other trau

Funeral

Director

Show

7 is marked other than "netural", or items 23a or 28e-f shov traumatic avant, the Medical Exantration intal be notified at

2 should be filed within 72 l and Mental Hygiene Is marked other than "netu

the Maryland

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical

physician and s the burial-tran use ō the the á Certification: To Be after death. in by within 24 hours aft

To the Funeral Di

completely filled in

Medical

act mursing racifile

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, State Control of Town, State Cont

KIDGE KO

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1	7
2	- 1

00

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

who completed caus of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

6 ☐ Could not be

3 Suicide

29a, Certifier

4 Thomicide

Registrar's Signature

10 05

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3...Time of Death (. 2005 **Physician** Year June 16, 12:24 a^M Kenneth John Trzcinski /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 19, 1950 9. Birthplace (State or Foreign **Funeral** Days Hours 1 MM 2 □ F 54 215-50-5168 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinating the notified at 1 ☐ Yes 2 ☐ No Street MD Harford Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21154 U.S.A. 4545 Madonna Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. and team of the than "natural", or Itel inter 27 Is marked other than "natural", or Itel 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3√No Specify: Specify: White ð 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Computer Consultant Bankino 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Floryan Trzcinski Dorothy Trzeciak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4545 Madonna Rd., Street, MD Theresa R. Trzcinski-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Important: If any injury or once. St. Mary Cemetery 6/20/05 Pylesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lice William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Concer JUNG disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cass (Class Chiff) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a to the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 25 205 a rress of person who completed cause of death tem 23a) (Type, Print) N. Chules St. Balto. MJ 21268 G mile 678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 0 2005 Registrar A Goods

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 14, 1:00 p June 2005 R. Turner **Eleanor** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Edenwald Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Zear)
Months Days Hours Min. NOVEMBEY 23, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F 1912 Pennsylvania 92 Yrs. 174-20-7764 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Show iral', or Itams 23e or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 No Towson MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21286 U.S.A. 800 Southerly Rd., Apt. 1217 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced natural led 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Public College (1-4or 5+) Elementary/Secondary (0-12) Teacher Schools 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Turner Emily Oberfell Pearson Marsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Southerly Ct., #207, Towson, MD 21286 Mildred H. Murray-friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Hilltop Service Corporation 6/17/05 Towson, MD *4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. permit.
Deportri 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INFRATTON disease or condition resulting in death) MUGCARDIM /Medical Due to (or as a consequence of): Examiner ORUNIAM 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Tes 2 5 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Other: 1 ☐ Yes 2 No 4 A rursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funerel Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗀 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centifier 127838 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21091 CAMP MRMILRO; SHAWENS

Registrar

State

32. Registrar's Signature

1 de la

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILMA GWENDOLYN TAYLOR 8:20 РМ June 8, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice of the Chesapeake Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🗓 F Virginia 233-38-4585 95 Yrs. 1909 Director Oct 6, W. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
and: If Item 27 is marked other than "netural", or Items 23s or 28s-1 show try or other traumatic event, the Medical Exaria ar marken institled at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 ☐ Yes 2√☐ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Holy Cross Road 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Dept. Of Education Baltimore City School System 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luther Soloman Cosner Statia Moon Anna ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Williford (Daughter) 310 Holy Cross Rd., Baltimore, Md. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 6/11/2005 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STEOPORO 10/EAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2-No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 21 No certificate 1 Tyes 1 Yes or Attending Physician: Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner plated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Date filed (Month, Day, Year) JUN 2 0 2005 DHMH 17 Rev 1/2001

CICHART

ISHETT 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CICHARD E L'SHEIZ 4710 PENNING TOA

	1	State of Maryland / Department of Health and M For Stata Ragistrar Stata Certificate of Death	ental Hyg	_
Physiciar /Medica Examine Funeral	n II r	1. Decedent's Name (First, Middle, Last) Cleo Timmons, Jr. 4b. City, Town, or Location of Death Maykand Creneral Hosp; fol Boult more Cry 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	2. Date of Dear Month JUNE 8. Date of Birth (Month, Day)	Day Year 203 p M 4c. County of Death N/A 9. Birtholace (State or Foreign
Director t show		213-90-3400	July 2	5,1967 Maryland 10d. Inside City Limits Variable Service Ser
with the Name of Sa or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code 21213	1	10g. Citizen of What Country?
urs after death	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Security Substitution of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 Yes, Give 1 Yes, Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
tiled within 72 hours after death with the Maryland Hygiene. Hygiene and a strain or terms 23a or 28a-f show ont, the Medical Ever in ear must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Dishwasher		16b. Kind of Business/Industry Restaurant
Jany and be filed fental Hyginked other tic event,	lo Be C	17. Father's Name (First, Middle, Last) Cleo Timmons, Sr. 18. Mother's Name Rosie		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examination to the rectified #1			Balti /05 tman-H	2,2.0
par par	cal Examiner	23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lequentially instructions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	or respiratory ari	Approximate Interval Between Onset and Death
that the death certificate that by the attending physic detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown		23d. Date of delivery Month Day Year
uires that the signed by lid be detact	by Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Munknown
ra ca	Completed		1 ☐ Yes	prior to completion of cause of death? 22No 1 Yes 2 No
his his	sation; To Be	27. Manner of Death 1 Accident Superscript 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Accident Injury 28c. Injury at Work? M 1 Yes 2 No	ome 5 Resid 28d. Describe h	dence 6 Other (Specify) now injury occurred
DIVIS	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow	
To the Hospital o within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Madical Examiner: On the basis of examiner: On the	red at the time,	date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
^		30. Name and address of person who completed cause of death (Item 23a), (Type, Print)	/ / /	reral Hospital
Star Registra		31. Date filed (Month, Day, Year) 32. Degistrar's Signature JUN 1 8 2005	UTEN	relac Hospital

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amend Please Type or Print in Black Indelible Ink. Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 81540M Underwood 9 une, cumes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hookins Bayview Medical Baltimore (enter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 15, 1958 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Washington DC 46 219-74-1204 Director Usual Residence of Deceden the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits irel', or Items 23e or 28e-f show Director 1√ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21206 5114 Belair Road USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Baltimore, Marvland 21215-0036 Specify: Specify: black 3 Widowed 4 Divorced naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Medical 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Õ mechanic automotive Pages 1 and 2 should be filed nent of Health and Mental Hygisht: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Underwood Ruth D. Hall ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Evans/sister 122 S. Collins Avenue Baltimore, MD item 27 i 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite any njury or ot once. 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 □ Donation 5 ₩Other (Specify) in state 6/25/05 Metro Crematory Catonsville, Maryland 22 Name and Address of Facility Parker Funeral Home, P.A. State Anatomy Hourd 555 W. Baltimore Street Ronald S. W. may 21201 Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ardrogonic disease or condition resulting in death) /Medical Due to (or as a consquence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the attending physician and ned for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ģ signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Wasan has 2 **X** No Denter certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No this 28c. Injury at Work? uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After To the Hospitel or Attending 1 Natural Injury 5 Pending 1 🗌 Yes 2 No death. 2 Accident investigation within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie June 2005 M.D. RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rayresh (Suipha) Eastern Ave Battimore, MD 21224 32/Registrar's Signature

DHMH 17 Rev 1/200

State

Registrar

JUN 2 0 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2005 **Physician** 11:00 A M Jane T. Vaughan /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 1011 Kennon Court Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Director 255-22-1516 December 11, 1922 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or Itams 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Rockville <u>Maryland</u> Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death v 1011 Kennon Court 20851 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itar XYes 2 ☐ No fYes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ Specify. If Yes, Give Year or Dates: WWII 7 is markad othar than "natural", traumatic evant, the Medical Ex White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15: Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Private Nursing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Spath Madeline Hernon ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) iges 1 and 2 s of Heaith an iff itam 27 ls i Carol M. Campbell/ Daughter 2821 Fry Road Jefferson, Maryland 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Saint Mary's Cemetery June 21,2005 Rockville, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 21. Signature of Furteral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Coronary Artery Disease 3 Years /Medical Due to (or as a consequence of): Examiner Hypercholesterolema Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 1 ☐ Yes 2 🗓 No Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 2 1 X Yes 2 ☐ No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 NR Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. ector: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funaral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier June 17, 2005 D26520 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) Phyllis Schreiner, M.D. 6000 Executive Boulevard #300, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. agistrar's Signature State JUN 2 0 2005 Registrar

		•	For State Registrar		State of Ma	aryland /		artment of F tificate of		h		Reg. No		2038	34	
H	Physici		Decedent's Name	(First, Middle, Las	Alma M.	Vigno]	La			2	2. Date of Dea Month June	Da	^{ay} 2005	3. Time of I	Death P ^M	
	/Medio Examin		4a. Facility Name (If	not institution, give	e street and number)			4b. City, Town, o	r Location	n of Death			c. County of Death	1		
			Holy Cros	s Hospit	a1			Silver	Spr	ing		1	Montgome	у		
	Funeral Director		5. Social Security Nu. 578–64–52		ex 7. Age	62	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. 8 6 Min. J	B. Date of Birt (Month, Day Jan. 3,	h Y, Year 19	9. Birth	place (State or ntry) LLY	Foreign	
	yland		Usual Residence of 10a. State	10b. County		10c. City, To	own or Lo	cation						10d. Inside Cit		
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic svant, the Medical Examinat must be nuffied at once.	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	_	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		t	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 213 No	an, Mexic Specii		ify Yes or No- ican, etc.)		14. Race - Ameri Black, White, Specify:			
Q Q	72 ho	eted	(Speci	15. Decedent's Edity only highest gra	ducation	1	6a. Deced	dent's Usual Occup	oation	ost of working	g l	16b. i	Kind of Business/In	dustry		
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auc	d be findal Head of) Be		DiLucci							ina Mo		•			
2	should nd Me mark matir	٥ ٢	19a. Informant's Na			1	19b. Mailir	ng Address (Street	1					Code)		
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Baltimore,	Pages 1 au ent of Hea nt: If itam ry or otha	7			Removal from State	1		sition (Name of matory or other place) Cemeters	1	June 2	21.		ocation - City or Tonantown,		nd	
Balti	permit. I Departm Importal any inju		21. Signature of Fur			M00198	Ro	Name and Addre Obert A. O West Mor	ss of Fac Pump	hrey F	uneral	Но	me/Rockv	ille, I	nc.	
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	/Medical		resulting in death)	-	a Due to (or as											
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_	≒ 00 €		IF FEMALE:													
P.O. Box	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/M	23b. Was decedent in the past 12 1 Yes 2 2 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	у			Ĭ	23d. Date of deliv Month		ear	
	s that ned b	by Ph	Part II. Other signifi	cant conditions	contributing to death b	ut not resultin	ıg in the u	nderlying cause giv	en in Par	rt I.	23e. Did to	obacco	use contribute to t	he cause of de	eath?	
rds	quires in sign										1 🗆 Y	es 2	Prol	oably 4 ⊠U	nknown	
000	law requir as been si 2 should I	Completed									24a. Was		24b. Were auto	ppsy findings a	vailable	
æ	The la	mo									perfo	rmed?	death?		use or	
ţa	siclan: Th certificate rector, pag	Bec	25. Was case referr	ed to medical					26. Pla	ice of Death ((Check only o					
<u>></u>	Physic this ce al dire	은	1 ☐ Yes 2🔀	No		nt 2 ER	/Outpatier	STORY OF THE PARTY	401				6 □Other (Special	5 y)		
ion c	or Attending Physician: ifter death. Diractor: After this certifics in by the funeral director, i	atlon:	27, Manner of Death 1	5 Pending investigatio	28a. Date of Inju (Month, Da)	ry y Year) 28	b. Time of Injury	Wor	ryat rk? Yes 2[_	3d. Describe h	now inju	ury occurred			
Division of Vital Records,	al or Attenos after deatl	Certification:	3 🗌 Suicide 4 🗍 Homicide	6 Could not be determined			, farm, str	reet, factory, office		28	Bf. Location (S City or Tox		nd Number or Run le)	al Route Numb	per,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one)		nysician: To the best miner: On the basis o and manner sta	examination										
)	To the within To the comp	¥	29b. Signature and	title of certifie	lin			29c. Licens	e numbe				ate signed (Month,			
	10		30. Name and addre	hopra, M	completed cause of d	Box 83	819,	Gaithers	sburg	g, Mary	yland 2	2088	33			
	Sta Registi		31. Date filed (Mont	JUN 2 0	2005 32. Registr	ar's Signature	4 1	parke								
		_														

VIGNOLA,

			State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Bag, No. 115 21385	
			I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	-
	Physicia /Medic		RYTH WASHINGTON Pay 2003 3.30 PM	
	Examin		a. Facility Name (If not institution, give street and number) OLD COURT NURSING (TOME LAWDALLS TOWN 4c. County of Death ALD TOWN ALLS TOWN	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Country) 9. Birthplace (State or Foreign (Month, Day, Year)	,
	Director		Jsual Residence of Decedent	_
	Marylar f show	jo	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No	
	r 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	23a c	alD	4410 BUCKINGHAM ROAD 21207 USA	
	er des Itema	unel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural, or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be nullified at once.	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Specify: BLACK	
2	"natur	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry	
212	d withir giene. rr than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) HOUSE KEEPER PRIVATE HOME	
Maryland 21215-0036	be filed Ital Hyg Id othe	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
2	thould ad Mer marks marks	ဥ	WALTER WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
<u>≅</u>	alth ar 27 Is		PATRICIA WEST (DAUGHTER) 110 S. ROCK GLEN RD., BALTO. MD 21229	
ore,	es 1 a of Hea fitam r oths		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
altimore,	Pag tment tant: I		'4 Donation 5 Other (Specify) BALTIMORE NATL. 106-22-05 BALTO. MD	
Bai	Depar Impor any in		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BAVO. MO 21229	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt-taffure. List only one cause on each line. Approximate Interval Between	
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	
	Examiner		Due to (or as a consequence of):	
	p =	iner	Sequentially list conditions, it any, leading to immediate ause. Enter Underlying	
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):	
8760,	icate be executed physician and s the burial-transit	dlcal	d	
9	entifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery	
Вох	es that the death certifi igned by the attending I be detached for use as	Physician/Me	230. Was decedent pregrant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year	
P.O.	at the	phys	9 □ Unknown	_
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown	
of Vital Records,	law requir as been si 2 should l	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of	,
<u>~</u>	ding Physician: The lawn. n. After this certificate has b funeral director, page 2 s	Com	performed? death? 1 Yes 2 No 1 Yes 2 No	
<u> </u>	Physician: r this certificanal director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
1 0	Phy rathis	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	_
sion	ttending F death. ctor: After y the funer.	atlo	2 Accident investigation M 1 Yes 2 No	
Division	l or Attendater deatl Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide See. Place of Injury - At home, farm, street, factory, office determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
_	To the Hospital or Attending within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	_
	o the lithin 2 o the I	Medi	29b. Signature and title of continuous and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	
	H 3 F 8		1 C / em 20 D 37333 JUNE 15, 2005	
1	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVI M NHT SATO M 7 Z 11 3 3 31. Date filed (Month, Day, Year) JUN 2 0 2005 32 Registrar's Signature	
	Sta	•	31. Date filed (Month, Day, Year) JUN 2 0 2005 32/Registrar's Signature	
	Registr	ar	00:12 0 5003 Ballies 22 Marie	

Talieha Marshall 05-04019 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici		1. Decedent's Name (First, Middle,	Last)						Date of De Month		Year	3. Time of Dea
/Media		Talitha Warfield							June	12	2005	
Examir	ner	4a. Facility Name (If not institution,		7)			Location o	of Death			County of Deat	
		1641 Gleneagle 5. Social Security Number		ge (In yrs. last birthday) If Under	1tim	ore		8. Date of Bir			re City thplace (State or For
Funeral Director		518 · 84 · 8128 Usual Residence of Decedent	1□M 2 K F	46 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 02 · 26	1959	Co	hplace (State or For buntry) MD
r 28e-f show	7	10a. State 10b. County		10c. City, Town or I								10d. Inside City Lin
28e-f	recto	MD N	n	BHILITIOR	10f. Zip	Code				10g. Citi:	zen of What Co	ountry?
23e or	i D	ILAI GLENEAGLE	ROAD			2123	9				USA	
or Items 2 miner ou	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Deceden Armed Forces 1 KYes 2		Was Deced If Yes, spec			gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit	e, etc.
	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates				Specify:					ACK
ien "naturel", Modical Ex	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40)	(Giv life.	edent's Usua e kind of wor DO NOT us	rk done d se retired)	uring mos	t of worki	ing	Wom	nd of Business NENS HO	
I Hygiene. other than /ent, Ire M		12 TH GRADE 17. Father's Name (First, Middle, L	4 YRS.	OFF	ICE IT	NANA		ar's Name	(First, Middle		LITION Sumama)	
\$ D .	To Be	GEORGE MARS					CARO	LYN	FLOOD			
ls m		19a, Informant's Name/Relationsh JOSEPH WARFI		1	ling Address GLENI				BALTI		r Town, State, 2	Zip Code) 21239
item 27 other tr		20a. Method of Disposition	LLD (HUGBA	20b. Place of Dispose				7-904	ate		cation - City or	
ent of nt: If ii ry or c		1 8 Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (Sp		FT. LINCOL		_		06.17	:05	BRE	ENTWOO	D, MD
Department of Health Importent: If item 23 eny injury or other 1 once.		21. Signature of Funeral Service L		v	22. Name and AUGHN (d Addres	s of Facilit	FUN	ERAL SEA	SAICE	00	•
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	ed the death. Do not e					Or respiratory a		(4)	Approximate Interval Betwee
nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)		e Disorder								Onset and Dea
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequence of):								
sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequence of):								
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DHMH 17 Rev 1/2001

		•	State of Maryland / Department of Health and N 1- State Registrer Certificate of Death		giene 005	20387
	Physici		1. Decedent's Name (First, Middle, Last) Kule Steven Wiagine	2. Date of Dea Month		3. Time of Death
	/Medic Examin		4a. Fadility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Maryland Medical Center Baltime	le.	4c. County of Deat	י
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day 12-21-2	h 9. Birth y, Year) 9. Birth Co 2004 Mary	nplace (State or Foreign untry) y land
	anyland show	7.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith tha Marylan or 28a-f show	Funeral Director	Maryland Howard Laurel 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	tar death w items 23a	eral [9382 Breamore Court 20723 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecity Yes or No-	United State	rican Indian,
036	ours aftar or iter	þ	Armed Forces? 1 X Never Married 2 Married 1 Yes, Sive 3 Widowed 4 Divorced Armed Forces? 1 Yes, Sive Year or Dates: If Yes, specify Cuban, Mexican, Puerro 1 Yes, Sive Year or Dates:	Rican, etc.)	Black, White	White
Baltimore, Maryland 21215-0036	gas 1 and 2 should ba filed within 72 hours aftar death with tha Maryland to fleatth and Mental Hygiene. I of Health and Mental Hygiene. I filem 27 is marked other than "neturel", or items 23a or 28a-f show or other treumatic avent, the Medical Examination or oliffied.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing .	16b. Kind of Business/	Industry
1d 21	a filed w I Hygier other th	Be Cor	0 Nevered Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	n/a Maiden Surname)	
r∨lar	should be filed nd Mental Hygi marked other umatic avent,	To B	Steven Richard Wiggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			(in Code)
Z Z	and 2 st ealth and n 27 is r		Steven R. Wiggins (father) 9382 Breamore Ct. Laure			
more	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic avent, Ite M. 2006.		1 Rurial 2 Cremation 3 Removal from State cemetery, crematory or other place)	Date -2005 I	20c. Location - City or 3 Brooklyn Par	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee J. Wayne Osterling 22. Name and Address of Facility McCully-Polyniak Fig. 130 E. Fort Ave. Ba	uneral H altimore	Home, P.A.)
	Dhunisian ³		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or head failure. List only one cause on each line.			Approximate Interval Between Onset and Death
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97 M	ate be executad hysician and the burial-transit	Examiner	Cause (bisease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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X & P	w requires that II been signed by should be detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Compley consent tal heart durase	23e. Did to	obacco use contribute to res 217 No 3 ☐ Pro	
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25 25	ding Physicien: The h. After this certificate h. funeral director, page	ion: T	27. Manner of Death 1 Natural 5 □ Pending 28a. Mee Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?		low injury occurred	,,
$\frac{\beta}{\beta}$ Division	or Attenutter deatl	Certification:	2 Accident	28f. Location (S City or Tow	Street and Number or Ru m, State)	ral Route Number,
	the Hospital hin 24 hours a the Funeral I	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place in the time, date	and due to the ored at the time, or	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th withir To th	Me	29b. Signature and the contriber MDP 1775	83	29d. Date signed (Month	Day, Year) - 2005
_			30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 22 South Grepne St. Rm NSE13 Baltin	nore,	MD 2	1201
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0 2005 32. Rigistrar's Signature	, 		

			17 17
State of Mar	yland / Department of	Health and Menta	Hygiene

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** June 16, 2005 Thomas Milton Wells 7:55 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner 2606 Triadelphia Lake Road Brookeville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Yrs. Director October 13, 1950 227-64-0722 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo <u>Maryland</u> Brookeville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a 2606 Triadelphia Lake Road 20833 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Item eny injury or other treumatic event, the Madical Examina-1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Chief Financial Officer Insurance 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Wilbur Francis Wells Ruth Somers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Jeansonne/ Sister In Law 228 Queens Court, San Carlos, California 94070 20b. Place of Disposition (Name of cemetery, crematory of other place)
Metropolitan
Crematorium 20a. Method of Disposition 20c. Location - City or Town, State June 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 17, 2005 Alexandria, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 21. Signature of Fyneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myeloid Leukemia 18 Months disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760. 99 Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy performed? 1 Yes 2X No To the Hospitel or Attending Physicien: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 X Natural 2 ☐ Accident 1 Tes 2 No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 \(\text{Homicide} \) within 24 hours a To the Funerel [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and adverse of berson upo completed cause of death (Item 23a) (Type, Print) Steven Gore, M.D. 1650 Orleans Street Baltimore, Maryland 21231 31. Date filed (Month, Day, Year) 37 Registrar's Signature State JUN 2 0 2005 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 21 Physician 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Examiner 600 If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 2, 28 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 226.38.9933 Days Hours Months 1 □ M 2 F inia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Fages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health and Mental Hygiene. Importa w: if item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other treumatic event, the Madical Examinational be notified an once. 10a State 1XYes 2 □ No Md Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Nobel Washington ☐Yes 2X No Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: Black à Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 66 ping 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. 19a. Informant's Name/Relationship (***) pe, Print) Kton 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State • 4 □ Donation 5 Other (Specify) 21. Signat Funeral Service Licensee Hom AVE · North Approximate Interval Between Onset and Death ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest for heart failure. List only one cause on each line. Immediate Cause (Final e2515 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed na that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy etten for u Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cete has autopsy 1 Yes 2 No certificete or Attending Physician: 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After thi Date of Injury (Month, Day Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 2 No 1 Yes investigation Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funerei Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier

State Registrar Date filed (Month, Pay, Year) 32. 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

CPM 05-03661 Edna Anderson

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27, 2005 Mav 12:48 P Edna Anderson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Min. Months Days Hours **Director** June 13, Wash., DC 579-36-4150 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar Frust be putified at 1 XYes 2 No <u>Maryland</u> Prince George's Fairmont Heights Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 1320 Farmingdale Ave. United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status within 72 hours after Yes 2 No 1 Never Married 2 Married Black 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H fitem 27 Is marked oth Be Heskia Bryant Edna Olden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7635 Muncy Rd., Landover, MD 20785 Angela E. Anderson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth 1 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 6/4/2005 Washington, DC ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home once 4001 Benning Rd., N.E. Wash., DC 20019 0 Xewaix WU 23a. Part1. Effor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a final function and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and statement of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock are discounted by the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock and shock are discounted by the death. Do not enter the death are discounted by the death are discounted by the death are discounted by the death are discounted by the death are Approximate Interval Between Onset and Death **Physician** a. STOKE INHALATION resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month 5 Other (specify) detached 9 Unknown signed by d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ nknown 1 ☐ Yes 2 ☐ No. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? page certificate 1⊈ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA examiner? 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ à 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Natural VICTIM OF 1 ☐ Yes 2 🗷 No HOUSE death. 2 Accident investigation 12:02PM 5127/05 filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide FAIRTONT HTS hours after ō 1320 FARTING DALE AVE, TO RESIDENZE To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME May 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 111 Penn Street Baltimore, Maryland 21201 RUBIO ANA 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 7 2005 Registrar

DHMH 17 Rev 1/2001

05-03658 THOMAS ANDERSON LINK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 20391 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Thomas Henry Anderson, Jr. 2005 May 12:17 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1320 Farmingdale Avenue Prince George's Fairmont Heights If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
June 27, Year) 924 9. Birthplace (State or Foreign **Funeral** 1 ★M 2 ☐ F 80 579-20-6907 Wash., DC Director Vrs Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r items 23a or 28a-f shov inter-ust be notified at Director Prince George's 1 ▼Yes 2 No Maryland Fairmont Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1320 Farmingdale Ave. 20743 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is markad othar than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black. Specify 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) $\overset{\text{Elementary/Secondary (0-12)}}{12\,\text{th}}$ College (1-4or 5+) Supervisor Sewer Department D.C. Government 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Henry Anderson Sarah (Unknown) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela E. Anderson-Daughter 7635 Muncy Rd., Landover, MD 20785 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any injury or once. ^ 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 6/4/2005 Washington, DC 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Fur eral Service Licensee Moon 4001 Benning Rd., N.E. Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of ondition Physician STOKE INHALATION AND THERMAL INTRIES resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2 No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Certification: To Yes 2 □ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending VICTIM OF HOSTE FIRE death. 2 Accident
3 Suicide
4 Homicide investigation 12:02 P M 1 ☐ Yes 2 No 5/27/05 after death Diractor: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by FAIRMONTHIS RESIDENCE 1320 FARMINGDALE AVE, within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Uluel OCME May 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 RUBIO, MD ANA

Registrar

DHMH 17 Rev 1/2001

State

JUN 0 7 2005

22. Registrar's Signature

ORIGINAL

RJ

			1 - For State Registrer	State of M	laryland / Dep <i>Ce</i>	ertment of Hertificate of I	lealth and Death		ene]]	5 20392
			1. Decedent's Name (First, Middle, La.	st)				2. Date of Death	1	3. Time of Death
	Physic /Medi		Annamay	Savilla	a Br	oadwater		June 11	, 2005 Ye	2:12 p. M
	Examir		4a. Facility Name (If not institution, give	street and number	7)	4b. City, Town, or	Location of Deat		4c. County of D	
1			Memorial Medical	Center		Cumberla	and		Allegan	Ÿ
	Funeral		5. Social Security Number 6. S		ge (In yrs. last birthda)		If Under 24 Hrs		9.	Birthplace (State or Foreign
	Director		219-19-4180	☐ M 2 🔀 F	17 Yrs.	Months Days	Hours Min.	Jan. 22,		Country) Maryland
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I					
	sho	7			Too. Oity, Town or t					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	ecto		rett		Swant	on			1 ☐ Yes 21€ No
	with a or	D	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	
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	ter d	Funeral Director	11. Marital Status1 Never Married 2 Married	Armed Forces	?	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	o Rican, etc.)		hite, etc.
336	hours after turel', or Ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
5-0036	72 hor	ted	15. Decedent's Ed		16a. Dec	edent's Usual Occupa	ation	. 1	6b. Kind of Busine	ss/Industry
21	hin 7 9. Med	Completed	(Specify only highest gra	de <i>completed)</i> College (1-4or	5+) (Giv life.	e kind of work done o DO NOT use retired	luring most of wor)	rking		•
2121	giene giene	NO.	11th	0011090 (1 401	0.,	Student			High So	chool
pu	e filed al Hygid other vent, II	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M		
Vla	outd be Mental sarked o	ပို	Gerald Pa	u1	Broadwate	r	Karen	Sue	:	Burgess
Maryland	and and Is m		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ing Address (Street a	and Number or Ru	ıral Route Number,	City or Town, State	a, Zip Code)
	1 and Health tem 27 other tr		Gerald P. Broadw	ater/Fath		Broadwate	r Lane,_	Swanton,	Md. 2156	1
Baltimore,	permit. Pages 1 am Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of omatory or other place	9)	Date 2	Oc. Location - City	or Town, State
Ë	Pag ment ant: lury o		`4 □Donation 5 □Other (Specify			er Family	Cem. 6	15/2005	Swanton,	Maryland
3all	Depart Import any in		21. Signature of Funeral Service Licen	6 00	2	2. Name and Addres	s of Facility	32	S. Secon	nd St.
_	40 E 8 9		Boully #	7		Stewart F			kland, Mo	1. 21550
	Fnysician /Medical Examiner	er	23a. Part1. Enter the disease, or composition, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a Due to (or as	s a consequence of):	Juries				Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	s a consequence of):					
P.O. Box	I the death certi by the attending ached for use a	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of o Month	delivery Day Year
	w requires that been signed b should be det	by	Part II. Other significant conditions of	ontributing to death I	out not resulting in the	underlying cause give	n in Part I.	23e. Did toba	. 1	to the cause of death? Probably 4 □Unknown
of Vital Records,		e Completed	25. Was area returned to madical					-	prior t death	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
Š	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpati	ant 27/27 CD/0	nt 30004 Othe	re .	th Check onl one	0.70	
of	y Phys or this oral dii	-	27. Manner of Death	28a. Date of Inju	ury 28b. Time o	III BUDA	- Unanging in	ome 5 Residen		pecify)
on	ding f th. : After funer	tior	1 ☐Natural 5 ☐ Pending investigation	(Month, Da	ay ar) Injury	Work 1 □ Y	es 2 No		of cos	IN Single
Division	Attending r death. ector: After by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be	286. Place of in	jury - At home, farm, st			28f. Location (Stre	et and Number or	Rural Route Number,
	after Dire	erti	4 Homicide	building, e	tc. (Specify)	ppt		City or Town	State) BH;	us Roed and
	splte		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, dea	h occurred at the time	e, date and place	and due to the cau	se(s) and manner	as stated.
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	iner: On the basis of and manner st	of examination and/or in	vestigation, in my op	inion, death occu	rred at the time, date	and place, and d	ue to the cause(s)
	To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by	Me	29b. Signature and title of certifier		0 0	29c, License			I. Date signed (Mo	
			Vota - 10	on '	-KUD.1-	OCI	IL.	Jt	me 12, 2	005
	5		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type	Print)11 D-	Charact	D-7.	- 34 3	1 01001
			PATRICIA A	-AD, U.S	KOLLAKA	CII rent	r prieer	Dalt1MO1	e, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	South :				

			1 - For Stata Ragistrar	State of Maryla		artment of F		, ,		
			Decedent's Name (First, Middle, Last,			timodito or i		2. Date of Death	J. No.	3. Time of Death
	Physici			Gene	BEIT	יספי		Month	*	eer M
	/Medi		Harland 4a. Facility Name (If not institution, give		DEL		Location of Deat	June 1	4c. County of I	9:30 A
	Examir	ier		areer and numbery				"	4c. County of t	Death
			110 F1at Street 5. Social Security Number 6. Sec	7 Age (in yo	s. last birthday)	If Under 1 Year	Accident If Under 24 Hrs.	O Data of Birth		rrett
	Funeral Director		15	M 2□F	Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	52				Mar. 22,	1953	Maryland
	land		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	f sh	5	740							1 ☑ Yes 2 ☐ No
	28a-	Director	MD Garre 10e. Street and Number	ett		Accid	ent	10-	0.00	
	with with	ā				Tot. Zip Code		109	. Citizen of Wha	it Country?
	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examinatioust be notified at	Funerai	110 Flat Street	10 Was Davidson Francis	11.0		21520			SA
	er de Item	n n		12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No- to Rican, etc.)		American tndian, White, etc.
3	s aft	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No tf Yes, Give		☐ Yes 2☑ No	Specify:		Specify:	White
3	hour luraf	D T		Year or Dates:	1 10 5					
ÿ	"na	Completed	15. Decedent's Edu (Specify only highest grade		Give	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of wor	rking 16	b. Kind of Busin	ess/Industry
51215-0036	withii ane. Ithen	E D	Elementary/Secondary (0-12)	College (1-4or 5+)						
	lled lygie lher nt, II	ပိ	12th 17. Father's Name (First, Middle, Last)		Lab	orer/Car			Constru	ction
Maryland	be f hital h d of	Be		. 7			18. Mother's Nar	ne (First, Middle, Ma	den Sumame)	
$\frac{8}{2}$	ould Mer Parke	2	Earl Samu		eitzel		Sidney	Mae	В	ittinger
ā	2 sh and is rr		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maitin	g Address (Street a	and Number or Ru	ıral Route Number, C	ity or Town, Sta	te, Zip Code)
	and ealth n 27 ner tr		Alverda Beachy/ A	unt	110 F	lat Stree	t. Acci	dent, Mary	land 21	520
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show appringury or other traumatic event, the Midical Examination in appres.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo	sition (Name of natory or other place		Date 20	c. Location - City	or Town, State
Ĕ	Pag nent int: f		'4 □Donation 5 □Other (Specify)		-	Luthera	1	4/05 A	and done	Maryland
<u>=</u>	mit. partn partn ports ports / inju		21. Signature of Funeral Service License			Name and Address			S. Seco	
ñ	Depa Impo eny ir		Brook MD	Don't	S	tewart Fu	meral H			d. 21550
			23a. Part1. Enter the disease, or compli	cations that caused the dea						
	B		shock, or heart failure. List only or tmmediate Cause (Final	e cause on each line.			, ,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Type II Dia						Years
	Examiner			Due to (or as a conse	quence of):					
		_		Due to (or as a conse						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Cissose or injury	Due to (or as a conse	quence on:					
	and and I-trar	кап	that initiated events resulting in death) Last	. Due to (or as a conse						
Š	ficate be executed physician and s the burial-transit	Ē		Due to (or as a conse	quence or);					
09/00	physi the t	edicai	d							
0			IF FEMALE:						1	
DOX	at the death certifi by the attending patached for use as	Physiclan/M	23b. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	nancy al death 3 🗆	Ectopic pregnancy			23d. Date of	
	e dea	Sic	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
5	at the	hy	9 Unknown							
'n	The law requires that the death certi te has been signed by the attending vage 2 should be detached for use a	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute	e to the cause of death?
2	w require been si should b							1 🗆 Yes	2 □ No 3 □	Probably Dunknown
Vital necords,	aw re	Completed						24a. Was an	24b. Were	autopsy findings available
Š	The I	Eo						autopsy performed	<pre>1? death</pre>	to completion of cause of
		0	25. Was case referred to medical				Of Place of Don	th (Check only one)	No 1UY	/es 2□No
	ysick is cer direct	0 8	examiner?	ospital: 1 Inpatient 2	ER/Outpatient	3CLDOA Othe				
5	r thi	h	27. Manner of Death	28a. Date of tnjury	28b. Time of	3 DOX	4 Li Nursing H	ome Residence		Specify)
DIVISION OF	ding f h. After funer	Ę.	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Intury	28c. Injury Work	? ′es 2 □ No		.(4.) 000000	
2	Attending Physician: It death. actor: After this certifica by the funeral director.	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome farm stre			28f Location (Street	t and Number of	Rural Route Number,
5	Diffe	ertification:	4 ☐ Homicide determined	buitding, etc. (Speci	fy)	or, rabiory, omos		City or Town, S	late)	nurar noble (4b)((ber,
	spitaf ours a neraf I	O	29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my ke	owledge doeth	and the state of t			()	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Diractor: completely filled in by the	edical	(Check only 2 Madical Examin	ician: To the best of my kn er: On the basis of examinand manner stated.	ation and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cause red at the time, date	and manner and place, and or	as stated, due to the cause(s)
	thin thin the	Me	29b. Signature and title of certifier	and manner stated.		29c. License	number	204	Data signed (44	anth Day Voorl
	8 7 8 7	1		ulli 20				29d.	Date signed (Mo	
	,						5154		6/13/2	2005
	10		30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type, F	rint)				
	Y		P. Daniel Miller	D.O. 69 Wol	Lf Acres	Drive,	Oakland.	Md. 21550)	
	Sta	9.	31. Date filed (Month, Day, Year) JUN 1 4 2	32. Registrar's Sign	ature	/				
	Registra	al I	2011 T # 7	UUJ F	18 1	CHARLES J				

			1 - For State Registrar	State of M	1arylan		artmen rtificate				-	giene Reg. No.	005	2039	m.Ja
	Physici	an.	1. Decedent's Name (First, Middl	e, Last)							2. Date of De	aath Day	Year	3. Time of Deat	th
	/Medic		Naomi Mae Bart	holomew								10TH		16:10	М
	Examir	ner	4a. Facility Name (If not institution	n, give street and number	r)		4b. City,	Town, or	Location of	of Death		4c. (County of Dea	ıth	
			MEMORIAL HOSPI					BERL				AL	LEGANY		
1	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2√2 F	ige (In yrs. 1 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept. 3	th Year	9. Bi	rthplace (State or Form ountry) y Land	eign
	Director		235-08-1971 Usual Residence of Decedent	_ A		113.					Sept.3	, 1919	Mar	yıand	
	show show		10a. State 10b. County		10c. City	y, Town or Lo	cation					·		10d. Inside City Lin	nits
	Many Fied	to	WV Miner	al	For	rt Ashl	οу							1 [] Yes 2 []	No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	h witi	ai D	HC 86, Box 5				26	719				USA			
	deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces		S. 13.			spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		4. Race - Am		
9	or Its		1 Never Married 2 X Marr				ires,sped 1 ☐ Yes 2		Specify:	i, Puerto	nican, etc.)		Black, Whi	te, etc.	
9	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show ited Examinat must be natified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	:		103 2	LESTINO	Specily.				Specify: W	hite	
7	72 na	Completed		t's Education st grade completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	k done d	ition uning mosi	t of work	ing	16b. Kin	d of Business	/Industry	
12	within iene. than	d d	Elementary/Secondary (0-12)	College (1-4or	5+)		omema]					Orm	Home		
2	illed Hygie othar		17. Father's Name (First, Middle,	Last)		пс	Jileliai		18 Mothe	r's Nam	e (First, Middle,				
Maryland 21215-0036	be be	To Be	John Humberson						Ethe	l Fr	azee				
	and 2 sauth an n 27 is ar trau		19a. Informant's Name/Relations Barton M. Barth			HC 86	5, Box	x 5,	Fort		al Route Number	er, City or 267		Zip Code)	
Baltimore,	italian i		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		7	lace of Dispo emetery, crem nbersor					0ate .4, 200		ation - City or endsvi		
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee			. Name and				ewman Fu ntsville			-	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death	. Do not ent	er the mode	of dying	, such as	cardiac (or respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	0 5	srat	ed -	D., .	do	1 -		lcer			Onset and Death	
	/Medical		resulting in death)	aue to (or as	s a consequ	ence of):	5 000		ricor		1001			(3 cered 2	
	Examiner	.	Sequentially list conditions	· Yeri	ton	1715								15 days	
	p tis	inei	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ierica of):								1,520	
	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to for ou											
8760,	be ex cien ourial			Due to (or as	s a consequ	ience or):									
	cate t	dicai		d.				_							
9 x	death certific attending plater use as t	Physician/Me	IF FEMALE:	23c. If yes, outcome	of prognar	201				-	-				
Вох	ath or or	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic pre					23	d. Date of de Month	ivery Day Year	
o.	the dy the ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time or de	radii 5	Other (spe	cuy)							
٣.	res that the de signed by the a be detached t		Part II. Other significant condition	ns contributing to death i	but not resul	Iting in the ur	derlying ca	use give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?	
rds	requires een sign hould be	d by									101	res 2 🕱	No 3 □ Pi	obably 4 Unknow	wn
Record	> 10 0	Completed				-					24a. Was	20	24h Were a	Itopsy findings availal	hla
Re	9 4 9	mc									autop perfo	rmed?		completion of cause of	
	ician: Th certificate rector, pag	Ö	25. Was case referred to medical						00 Bl	-4 D4	1 Yes		1 🗌 Yes	2 No	
	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 🔏 No	Hospital:	ant 2 🗆 E	ER/Outpatient	3[] [00	04			n <i>Check onl</i> o		7011		
	g Phy erthi	L.	27. Manner of Death	28a. Date of Inju (Month, Da	-	28b. Time of		c. Injury			28d. Describe h			city)	-
<u>o</u>	ath. r: Aft	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		ay rear)	Injury	М		? es 2 🗆 N	No					
Division	r Attending er death. ractor: After by the funer	ific	3 Suicide 6 Could r	ined 28e. Place of In	jury - At hor	me, farm, stre	et, factory,	office		1			Number or Re	ıral Route Number,	
$\overline{}$	s after al Dira	Certification:	4 [Hornicide	building, e	tc. (Specify)	,					City or Tow	m, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis of and manner st	of examination attention of the second contract of the second contra	on and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, deat	d place, a	and due to the ded at the time, d	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)	
	To the troit of th	M	29b. Signature and title of certifier	H. Cho	Carri		29c.	License	number		:	29d. Date :	signed (Mont	h, Day, Year)	
			•	11 0230				D58	853			Jur	re la	2,2005	
			30. Name and address of person	who completed cause of	death (Item	23а) (Туре, Р	Print)								
			CHOTANI, HABIB	A., M.D.,	130 PE	ENNSYL	VANIA	AVE	NUE,	CUME	BERLAND,	MD	21502		
	Sta		31. Date filed (Month, Day, Year) JUN 1.		rar's Signatu		back	n							
	Registr	वा	A A 1/1 T	- 5000	TAR.	No Mi	A second from								

			For State Registrar	State of	Maryland /		artment of F		and Mental Hy	gien Reg. N	27 29 20 2	2020
			Decedent's Name (First, Middle, I	Last)					2. Date of De	ath	- 4113 -	3: Time of Death
	Physici /Medic		MICHAEL			BLO	UNT		JUNE	υ <u>,</u>	² , 2005 ^{ar}	5:38P. [™]
	Examir		4a. Facility Name (If not institution, g PRINCE GEORGES H				4b. City, Town, o		of Death	-	c. County of Death	RGES
	Funeral Director		5. Social Security Number 6 217-72-4747	. Sex 7. 1⊠M 2□F	Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bir (Month, Da DECEMB	ау, Үөаг	1958 9. Birthp Coun	* '
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ocation				1	0d. Inside City Limits
	sho	៦		CDOD CT La				a			'	1X Yes 2 □ No
	with the Maryland a or 28a-1 show be notified at	Director	MD PRINCE 10e. Street and Number	GEORGE'S	DIS	TRIC	10f. Zip Code	S		10g. C	itizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show rmat be notified at		6609 EVANSTON	STREET			20747				S.A.	,
	after death v or Items 236	Funeral	11. Marital Status	12. Was Decede			Was Decedent of H	ispanic Ori	gin? (Specify Yes or No n, Puerto Rican, etc.)		14. Race - Americ	
920	filed within 72 hours after Hygiene. vthar than "natural", or Ite ant, I're Medical Evanine	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒Divorced	Armed Force 1 X Yes 2 If Yes, Give Year or Date	_{□No} 3/86		1 □ Yes 2 X No	Specify:	i, Fuelto filoari, etc.)		Black, White, Specify: BI	ACK
Maryland 21215-0036	hin 72 hours an "natural", Medical Eva	Completed	15. Decedent's (Specify only highest)	Education grade completed)	16	(Give	dent's Usual Occup	durina mos	t of working	16b. I	Kind of Business/Ind	dustry
121	d within giene. ir than "	ldm	Elementary/Secondary (0-12)	College (1-4 5 y	or 5+)		DO NOT use retired 1PUTER TE	,			PRIVATE	
d 2	a filed within Hygiene. other then	ပိ	17. Father's Name (First, Middle, La		15	001	II OILK IL		er's Name (First, Middle	, Maide		
<u>lan</u>	o d lb	To Be	SAMUEL BLOUNT S	SR.				RU	TH B. WHIT	Е		
lary	of Health and Me of Health and Me litem 27 Is mark rother treumatic	.	19a. Informant's Name/Relationship	(Type, Print)					er or Rural Route Numb			
	and lealth m 27 her tr		RUTH BLOUNT/MO	THER		mn		ST. I	Date Date			
ore	Pages 1 nent of H int: If ita		20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Sta	te ceme	tery, crei	sition (Name of natory or other place				ocation - City or To LTENHAM , M	
Baltimore,	iit. Pa artmer ortant njury	i	* 4 □ Donation 5 □ Other (Spe 21. Signature of Emeral 2. Note Life		MARYI	_	VETERAN Name and Addre		6/10/05 y J. B. JEN			
Ba	permit. Pages 1 Department of H Important: If iten any injury or otf		1000	W >	>	-			ROAD LANDOV			20785
	4)		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cau ly one cause on eac	sed the death. D	o not ent	er the mode of dyin	g, such as	cardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_a. He	ad and	NO	uk inj	unie	3			Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):						
	變	er	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b Due to (or	as a consequenc	e of):						
	outed nd ransit	Examine	that initiated events	С.								
90,	cate be executed by sician and the burial-transit	I Ex	resulting in death) Last	Due to (or	as a consequenc	e of):						
92/89	cate phys	dical		d								
Вох 6	eath certific attending p I for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy	ith 3[Ectopic pregnancy	,			23d. Date of delive	ry Day Year
P.O. E	that the dea ed by the at detached fo	Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of death	5 [Other (specify)				MORE	Day
rds, P	quires that n signed b	δ	Part II. Other significant conditions	s contributing to deat	h but not resulting	g in the u	nderlying cause giv	en in Part I	, 23e. Did t		use contribute to th	e cause of death? ably 4 □Unknown
Vital Records,	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	Completed					· · · · · ·				prior to con death?	psy findings available inpletion of cause of
ta		O	25. Was case referred to medical	E				26. Place	of Death (Check only		3 174.55	20,10
of V	d is	To B	examiner? 1x⊟xYes 2 □ No	Hospital: 1 ☐ Inp	atient 2 X ER/0	Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nu	ırsing Home 5 ☐ Resi	dence	6 □Other (Specify	<i>'</i>)
0	ding Ph		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of l (Month,	Day Year)	Time o	Wor	k?	28d. Describe			
Division	Attanding r death. actor: After by the fune	cat	2 Accident investigat 3 ☐ Suicide 6 ☐ Could no	ho U-Z	-	d 5:	2	Yes 2 💢	28f Location /	Street a	nd Number or Bura	I Route Number
Div	tal or Al	Certification:	4 Homicide determine	building	etc. (Specify)	A+	eet, factory, office home		City or To	wn, Stat		Ima Ave
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examination	lge, deat and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, and due to the th occurred at the time,	cause(s date an	s) and manner as st d place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Month, I	Day, Year)
			I him h	w, mi	()					JUNE	3, 2005	
CK	2 (1)		30. Name and address of person wh	LT, M	of death (Item 23a	a) (Type,	111 Pen	n Str	eet Baltir	nore	, Marylan	nd 21201
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 7 20	37 Reg	istrar's Signature	April	de					

			For Stata Registrar		State of	f Marylaı		artmen <i>rtificat</i>			and M	lental Hyg	iene	O 00 -	
1	Pm . F		Decedent's Name (First, Mid	dle, Last)								2. Date of Dear	th	6000	3Time of Death
	Physic		Mabel	Ва	ttle							Month May	Day		5:45am M
	/Medi Examir		4a. Fecility Name (If not instituti			nber)		4b. City,	Town, or	Location of	of Death	TICLY .		County of Deat	
			Washington A	dven	tist H	ospita	1	Take	oma 1	Park			Mc	ntgomer	·v
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs			1 Year Days		24 Hrs. Min.	8. Date of Birth (Month, Day		9. Birtt	hplace (State or Foreign untry)
	Director		577-24-6672	10	M 20XF	92	Yrs.	WORKIS	Days	riouis	IVIII I.	July 12	19		rginia
	D >		Usuel Residence of Decedent 10a, State 10b, Coun			100.0	ity, Town or Lo								
	anyla shov	_		ıy		100.0									10d. Inside City Limits 1 X Yes 2 □ No
	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28e-f show Ita Madical Examiliar I atal Kamulihed at	Director	DC				Washir	7							
	or 2		10e. Street and Number					10f. Zip				1	0g. Citi	izen of What Co	untry?
	ath v	Funeral	118 Michigan						200					ited St	
	be filed within 72 hours after dea tal Hygiene. d other than "natural", or itams event, tra Medical Exertified.	nue	11. Marital Status		Armed For		J.S. 13.	Was Deced If Yes, spec	dent of H cify Cuba	ispanic Ori n, Mexican	gin? (Spe ı, Puerto	ecify Yes or No- Rican, etc.)		 Race - Amer Black, White 	
20	s afte	by F	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Giv	0		1 🗆 Yes	2 X No	Specify:				Specify: B1	ack
3	72 hours "natural", edical Eve	pé b	15. Decede		Year or Da	105:	162 Dogg	dont's Have	1 00000	ntion		-	10h K		
ÿ	n 72	Completed	(Specify only high	est grade			(Give	dent's Usua kind of wo DO NOT us	rk done d	durina most	t of worki	ng	IOD. KI	nd of Business/I	industry
7	withii iene. than	щć	Elementary/Secondary (0-12)		College (1	-4or 5+)		sekee		,			- 10		
Maryland 21215-0036	filed within Hygiene. other than ent, tre M		17. Father's Name (First, Middle	a, Last)			1100	sekee	per	18. Mothe	r's Name	(First, Middle, I		rivate	
<u>a</u>		o Be	Willie Winkl	er						E14.	zaho	th (Unkn		`	
<u>-</u>	d 2 should be fith and Mental I is marked of treumetic eve	T _o	19a. Informant's Name/Relation		e. Print)		19b. Mailii	na Address	(Street a			I Route Number		<u> </u>	in Code)
Z Z	7 1 2		Charles Tolb			dean									DC 20017
	E 5		20a. Method of Disposition		, oran	20b.	Place of Dispo	sition (Nan	ne of					cation - City or	
2	ages of of t: If i		1 ABurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other		emoval from S	STATE	cemetery, crei arvland				Мэл	27,2005	т.	aurel,M	D
	artme artme orten injury		24. Signature of Funeral Service		e 1\	4									
ם מ	permit. Pages 1 Department of H Importent: If ite any injury or ot ance.		() Velni	m	110	150		617 r	A	rexamo	der S	S.Pope F	une	ral Hom	e
			23a. Part1. Enter the disease,	or complic	ations that ca	aused the dea						Washing		DC 200	Approximate
			shock, or heart failure. Li Immediate Cause (Final	st only on	e cause on ea	ach line.			, , , ,	3,		, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
- 1	nysician /Medical		disease or condition resulting in death)	a			Emil	7							
	Examiner					or as a conse		1-1-1		(n	ilm	eNIC)	1		
		<u>ا</u>	Sequentially list conditions,	b.	District	or as a donse	allience offi	6713	<i>C</i>	(~	,,,,,	in ic			
	nsit	nin	cause. Enter Underlying Cause (Disease or injury	≺											
	exect nand al-tra	Examiner	that initiated events resulting in death) Last	C.	Due to (or as a conse	quence of):								
00/00	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical													
00	flicate g phy is the	edic		u.											
ממ	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23		come of pregn							2	23d. Date of deliv	verv
	death a atte	cla	in the past 12 months?	34.		irth 2□Feta ant at time of d		JEctopic pr] Other (sp						Month	Day Year
9	at the de by the tached	SyL	9 Unknown		9□ Unkno	wn									
Τ.	s that ned t	by P	Part II. Other significant condi	tions con	ributing to de	ath but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did tob	acco u	se contribute to	the cause of death?
3	aures n sign		END STAGE	- K	ENA	Y D.	SEAS	(E, I	7TH	EKO.	SCLI	1 ☐ Ye	s 2[□No 3□Pro	bably 4 Unknown
Vital Records,	s been si	ompleted	ROTIC HE	AK	- 101	SMI	E, A	TRI	41	F1B	11.	24a. Was ar		24b. Were aut	topsy findings available
2	The larate has	mc	1 1 1 - 1 1 1			-			3		-	autops: perform	ned?	death?	ompletion of cause of
		C	25. Was case referred to medic		190/0	-5 16	remt	$v_{7/}$	[-]	00 Pl	-4 D4b		28.No	1 🗆 Yes	2 No
5		o B	examiner? 1 ☐ Yes 2 🔀 No	- h-	ospital:	anationt 3	ER/Outpatier	. 2	Othe			(Check only one no 5 ☐ Reside			201
5	Phys r this ral di		27. Manner of Death		28a. Date o	of Injury	28b. Time of		8c. Injury			28d. Describe ho			ny)
5	ding h. Afte fune	tlor	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Monti	h, Day Year)	Injury	М	Work	(? Yes 2 □ N	1				
DIVISION	Attendii death. ctor: A y the fu	fica	3 Suicide 6 Coul	not be	28e. Place	of Injury - At h	ome, farm, str	eet, factory	, office		2	28f. Location (St	reet and	d Number or Rui	ral Route Number,
5	or Attending P after death. I Director: After I d in by the funera	Certification:	4 Homicide		buildin	ng, etc. (Speci	ry)	,				City or Town	. State)		
	spite		29a. Certifier 12 Certify	ing Phys	cian: To the	best of my kn	owledge, deatl	occurred	at the tim	e, date and	d place, a	and due to the ca	use(s)	and manner as	stated.
	To the Hospitel or Attending within 24 hours attended. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medice one)	I Exemin	er: On the ba and mann	isis of examina	ation and/or in	vestigation,	in my op	oinion, deat	h occurre	ed at the time, da	ite and	place, and due	to the cause(s)
	Nithir No th	Me	29b. Signature and title of certif	ier				290	. License	number		29	d. Date	e signed (Month	. Day, Year)
	- > - 0		Masin	71.	Tal	V 82	117		DA	158	77	4	/	1/2/11	_
p.	10		30. Name and address of person	n who car	npleted cause	e of death (Ite	m 23a) (Tvpa	Print)	100	- 0				1 -10.	4
U	K (3)		1160 Varn				Was		ator	, D	<u> </u>	2001	1 <	buite#	213
	Sta	ite	31. Date filed (Month, Day, Yea	r)	2. Re	egistrar's Sign	ature	40	J						
	Registr	_	JUN 0 7	ረሀሀኃ	Blank	w #	4000	1							

DHMH 17 Rev 1/2001

			For State Registrar	State of M	arylar	•	artment of rtificate o		and M		giene.	2005	20397
	Dhusisi		1. Decedent's Name (First, Midd)	e, Last)						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		James	Bowman	n					05 -	25 -	2005	19:11 p ^M
	Examin	er	4a. Facility Name (If not institution	n, give street and number)			4b. City, Town					ounty of Death	
			Ft. Washington 5. Social Security Number		in (In vrs	last birthday)	Ft. W	ashing		8 Date of Birt		ince G	
	Funeral Director		249-62-8107	1X1M 2□F	65 65		Months Day		Min.	8. Date of Birt (Month, Da 12–12 –	y, Year) 1 0 3 0		place (State or Foreign intry) th Carolina
			Usual Residence of Decedent							12 12	1.737	Bout	
	nylan how		10a. State 10b. County			y, Town or Lo							10d. Inside City Limits
	Ba-f s	cto	Maryland P.G.		Ft.	Washi							1 ☐ Yes 2√☐ No
	vith th	Funeral Director	10e. Street and Number	D 1			10f. Zip Code					n of What Cou	intry?
	s 23g	srai	12021 Livingsto	n Koad 12. Was Decedent	Ever in II	S 13		744	ain? (Sne	city Yes or No		SA . Race - Ameri	ican Indian
	ther de	Lun	11. Marital Status 1 □ Never Married 2 ▼ Mar	Armed Forces?		.5.	Was Decedent of f Yes, specify Co	uban, Mexicar	, Puerto	Rican, etc.)		Black, White	
93	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show re Medical Exeminer must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2X□ N	o Specify:			Sį	pecify: B1	.ack
5	72 ho	Completed		t's Education st grade completed)		16a. Dece	dent's Usual Occ kind of work dor	upation ne during mos	t of workii	ng	16b. Kind	of Business/Ir	ndustry
21215-0036	ithin ne.	npie.	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use reti	red)			Com		-
2	lled w lygier har ti	S	7 17. Father's Name (First, Middle,	(ast)		Labor	er	18 Mothe	ar's Name	(First, Middle,		structi	.011
and	d ba f	Be c	Willie Cannon	2401/						owman		,	
Maryland	shoul nd Me mark	2	19a. Informant's Name/Relations	hip (Type, Print)		19b Maili	ng Address (Stre GOOd Li	et and Numbe	er or Ryra	I Route Numbe	er, City or T	own, State, Zi	p Code)
	is 1 and 2 is 1 and 2 is 1 Health air Item 27 Is		Shirley Smith	/Daughter		Lanh	am, Mar	ick koa /land.	2070	6			
J.e	ss 1 a of Hea Item		20a. Method of Disposition	2 CB		Place of Dispo	sition (Name of natory or other p	1		ate	20c. Loca	tion - City or T	own, State
<u>=</u>	Page nent ant: M		1 🕅 Burial 2 □ Cremation '4 □ Donation 5 □ Other (S		Ft		oln Ceme	-				twood,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, the Medical Examinat must be notified at once.		21. Signature of Funeral Service	Licensee	.,7>		Name and Add 447 14th						me, Inc.
ш	40 E 4 9		Wanga C.	Bacon, C	C 30	0						. 20010	Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	ine. Zumw	nia, W		ying, such as		Tospilatory at			Interval Between Onset and Death
8760,	ate be axecuted nysician and he burial-transit	icai Examiner	Sequentially list conditions, in any, leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as d.									
P.O. Box 68	law requires that the death certifics as been signed by the attending pt 2 should be delachad for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	Ectopic pregnar Other (specify)	ncy			230	1. Date of deliv Month	ery Day Year
	luires that n signed b ıld be deta	by	Part II. Other significant conditi	3	out not res	ulting in the u	nderlying cause	given in Part I.	,	23e. Did to			he cause of death? bably 4 Unknown
Vital Records,	The law requir ate has been s page 2 should	Completed								24a. Was autop perfor		24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
/ita	Attending Physician: The rideath. sctor: After this certificate his by the funeral director, page	Be (25. Was case referred to medica examiner?						of Death	(Check only o	ne)		
	Physic this c	ို	1 Yes 2 No	Hospital:		ER/Outpatier	IL JUDON			ne 5 🗆 Resid			fy)
Division of	ding F h. After funera	ion	27. Manner of Death Natural 5 Pendir		y Year)	28b. Time of Injury	W	juryat /ork? □Yes 2□:		sad. Describe n	iow injury o	ccanea	
<u>s</u>	or Attendiater death Diractor: A	licat	2 Accident investi	not be an Place of Ini	iury - At h	ome, farm, str				28f. Location (S	Street and N	lumber or Run	al Route Number,
$\frac{2}{\Box}$	Dir	Certification:	4 Homicide	building, el	ic. (Specif	(y)	,			City or Tow	m, State)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: After the completely filled in by the funeral	edicai C		ng Physician: To the best Examiner: On the basis of and manner st	of examina								
	To th withir To th comp	Me	29b. Signature and tipe of certifie	г			29c. Lice	nse number			29d. Date s	igned (Month,	Day, Year)
			Nem	Com -			D00	55120			MAY	26	2005
R	(3)		30. Name and address of Berson	who completed cause of or	Jon!	n 23a) (Type, Hem A		Smit 31	0 h	lashing to	n DC	2003	2
	Sta Registr		31. Date filed (Month, Day, Year)	2005 Registr	rar's Sign	Aure Apr	de			,			

			1- For State Registrar amend item			partment of H			ene g. No.2 0 0 5	20398
I	Physici		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month May	3°Y 2'0°05	3. Time of Death 2:34 PM
	/Medio Examir		4a. Facility Name (If not institution, give s Holy Cross Hos				Location of Death		4c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Sex 406–18–0481	7. Age	9 (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 22,	9. Birth	nplace (State or Foreign intry) ntucky
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Mar	ctor	Maryland Montgo	mery			lver Spri	ing		1 X Yes 2 □ No
	th with th	al Director	10e. Street and Number 2010 Fairland R	oad		10f. Zip Code	20904	10	g. Citizen of What Co United	*
36	be filed within 72 hours after death with the Maryland that Hygiene. of other than "natural", or items 23a or 28a-1 ehow event, the Medical Examinar must be multified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: N	
9-00	2 hou	ted	15. Decedent's Educ	cation	16a. D	ecedent's Usual Occupative kind of work done of	ation	lina 10	6b. Kind of Business/I	
21215-0036	should be filed within 7 nd Mental Hygiene. marked other than "r imatic event, the Med	Completed	(Specify only highest grade	College (1-4or 5	- lin	e. DO NOT use retired	during most of wor	King	Child Ca	re/Private
pu	be filed ttal Hygid of other event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Maryland	Mer	7	A. Donald Br		19h M	ailing Address (Street	and Number or Rui		Humble	in Code)
	S is		James Bryant - B			513 Woodwe				20906
altimore,	ges 1 and 2 t of Heelth if item 27 or other tr		20a. Method of Disposition 1 Durial 2 Cremation 3 Re		20b. Place of D	sposition (Name of crematory or other place		-	0c. Location - City or 1	own, State
tim	nit. Pag artment ortant: I injury o		`4 ☐ Donation 5 ☐ Other (Specify)		Lincoln	Memorial			Suitland	, MD
Bal	permit. Pages. Department of H Important: If ite any injury or ot once.	, ii	21. Signature of Fulleral Service License	Laway	II		ning Rd.,	N.E. Wa	neral Home sh., DC 20	019
			23a. Part 1 Enter the disease, or complice shock, or heart failure. List only on	ations that caused e cause on each lin	the death. Do not ie.	enter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		iac Arrhy a consequence of):					
	Examiner			Due to (or as a	a consequence on.					
	De #S	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause & Decase or narry that initiated events	Due to (or as a	a consequence of):			M		
	xecute and al-tran	Examine	that initiated events resulting in death) Last	Due to (or as a	a consequence of):		0	EXAMINE	-R	
68760,	ficate be executed physician and is the burial-transit	edicai E	d			CERTIFIC	ATION APPROVED B	Y MEDICAL EXAMINE		
Box	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	3c. If yes, outcome of 1 Live birth 3c.	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	•		23d. Date of deliv	very Day Year
P.0	that the dended by the a	Phys	9 Unknown	9□ Unknown			and a Book I	On Didasha		the course of decays 2
of Vital Records,	w requires the been signer should be d	ted by	Part II. Other significant conditions con DM - Type 2	inoding to death bu	at not resulting in th	e underlying cause give	en in Parti.	1 🗆 Yes	acco use contribute to	bably 4 \(\subseteq Unknown
Seco	e law r has be ge 2 sh	Completed	Hypertension					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
alF		e Cor	Quadriplegia 25. Was case referred to medical	/Cervica	al Stenos	sis 			No 1 ☐ Yes	210 No
i S	d is	o Be	examiner?	ospital:	nt 2□ER/Outpa	tient 3 DOA Othe		th <i>(Check only one)</i> ome 5 Residen	ce 6 Other (Spec	(fv)
	nding Ph ith. :: After th e funeral	tion: 1	27. Manner eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Tim (Year) Inju	ry Worl	yat k? Yes 2 □ No	28d. Describe how	v injury occurred	
Division	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be determine 1	28e. Place of Inju building, etc	ury - At home, farm c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of ner: On the basis of and manner sta	examination and/o	eath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To the within 2: To the I complete	Me	29b. Signature and title	2	2-1	29c. License	s number 3597	290	d. Date signed (Month)	Day, Year)
N	(4)		30. Name and address of person who con			pe, Print) Sh	ahryar Da	avari, M.		
	Sta	to.	31. Date filed (Month, Day, Year)	<u> </u>	ar's Signature	Silver:	sping,	MD JE	0110	
	Registr		JUN 0 7 2005	Kenne	. K. A.	made	,			

amend it Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** HUPM Batters vesta 06 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomer Suburban | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 10, 1912 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ☐ ¥F 92 009-01-0676 Vermont Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hydjene. Illimportant: If time 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other traumatic axest. 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Director DCNone Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5315 Connecticut Ave., NW #309 20015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Newspaper and College (1-4or 5+) Elementary/Secondary (0-12) Advertising Writer Magazine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John E. Ridlon ပ Vesta Niles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Burchard/Friend 5265 N. 26th St., Arlington, Va. 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. 4 □ Donation 5 □ Other (Specify) June 6, 05 Silver Spring, Md. d 21. Signature of Juneral Service License 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 D.L 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Sepsis Immediate Cause (Final Physician 5/29/05 disease or condition resulting in death) Due to (or as a consequence of): Modifi /Medical Examiner Multi-system organ failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted use as the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 400 Unknown 1 Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy med? 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 1 Natural
2 Accident 5 Pending investigation 1 Tyes 2 No neral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D055480 .005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 armody Brenoan 32. Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink Ensure All Conic

			For State Registrar	State		and / Dep		t of H	lealth a		lental Hy	giene		20400
			1. Decedent's Name (First, Midd	le, Last)			Timout	0 01 2	Joann		2. Date of Dea	Reg. No.	- 0 0	3. Time of Death
	Physici		University Document Dr.	~~							June 13	Day	Year	9:30P M
	/Medic Examin		Harry Roger B 4a. Facility Name (If not institution		number)		4b. City.	Town, or	Location of	of Death	oune 13		nty of Death	J 9.30F
	LXamii	ici	1907 Hibbings	Place	,				le Gra				Harfor	A
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt			place (State or Foreign
	Director		162-26-2709	1 <mark>1</mark> M 2□1	F .	72 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day 02/23/	y, Year) 1933	Cou	land
	p .		Usual Residence of Decedent								, , , , ,		2	
	urylar show	_	10a. State 10b. County	/	10c	. City, Town or L	ocation						1	10d. Inside City Limits
	Ba-f.s	cto	MD Har	ford	Ha	avre de	Grace	ž						1 ☐ Yes 2 No
	or 24	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	ath w	ra	1907 Hibbings	Place			2	21078	3			U.S	.A.	
	er de Items er n	Funeral	11. Marital Status	Armed	Decedent Ever i I Forces?	n U.S. 13.	Was Deced	dent of Hi	ispanic Ori n, Mexicar	gin? (Sp.	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
36	hours after death with the Maryland tural, or Items 23a or 28a-1 show Examiner must be notified at	by F	1 ☐ Never Married 2 ĀMai 3 ☐ Widowed 4 ☐ Divorcei	If Yes.	es 2 □ No Give	F2 F4	1 🗆 Yes	2 □X No	Specify:			Spe	cify:	
8	d within 72 hours after death with the Marylan jene. r than "natural", or Items 23a or 28a-1 show the Medical Examiner man Le nelliked at	ed k		nt's Education	or Dates: 19		edent's Usua	al Occupa	ation			165 Kind of	Whi	
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p	H Hyg	BeC	17. Father's Name (First, Middle					1011		r's Name	e (First, Middle,			
<u>a</u>	D 0 0 0	To B	Walter K. Brow	٧n					Glad	dys (Orr			
Maryland 21215-0036	2 should and Men Is marka aumatic		19a. Informant's Name/Relation			19b. Mail	ing Address	(Street a			al Route Numbe	r, City or Tov	vn, State, Zip	Code)
	ages 1 and 2 should to f Health and Mer if itam 27 is marke or other traumatic		Pauline Brown	(Wife)		190	7 Hibb	ings	Plac	ce, l	Havre de	e Grace	e, MD	21078
ē,	is 1 and of Health itam 27 other tr		20a. Method of Disposition			b. Place of Disp	osition (Nan	ne of			Date	20c. Locatio		
Ĕ	Pages nent of int: If it		1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (el Air N	•			06/1	7/2005	Bel A	ir, Ma	ryland
Baltimore,	permit. Pages Department of Important: If i any injury or once		21. Signature of F meral Service	Licensee	M		2. Name an	d Addres	_	-				-
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п			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications the	at caused the c	leath. Do not er	ter the mod	e of dyin.	, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Pnysician _i		Immediate Cause (Final disease or condition		Molto	Site			ono					Poset and Death
	/Medical		resulting in death)	Due	to (or as a con	sequence of):				pu				a monume
	Examiner		Sequentially list conditions	b. ——										
7/	יק על קלי על	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due	to (or as a con	sequence of):								
V	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c.										
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Вох	atter I for L	ciar	23b. Was decedent pregnant in the past 12 months?	1□Liv	re birth 2 □ F egnant at time	etal death 3	☐Ectopic pro						Date of delive Month	Day Year
o.	the d y the iched	Physician/M	1 □ Yes 2 □ No 9 □ Unknown		nknown		_ 011.01 (3)	y/						
σ.	that ned b		Part II. Other significant conditi	ons contributing to	o death but not	resulting in the	underlying ca	ause give	n in Part I.		23e. Did to	bacco use co	ontribute to th	ne cause of death?
rds	quires n sign	d by									1 🗀 Y	es 2 No	3 🗆 Prob	ably 4 Unknown
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Vital		e C	25. Was case referred to medica	u T					26 Place	of Death	1 ☐ Yes	2 No	1 🗆 Yes	2 No
<u>></u>	ysici s cer direci	o B	examiner? 1 ☐ Yes	Hospital:	☐ Inpatient 2	ER/Outpatie	nt 3 DO	A Othe	ar-		me -5 ***Tesid		ther (Specifi	()
J Of	Attending Physician: r death. actor: After this certifici	T:u	27. Manner Death	28a. Da	ite of Injury fonth, Day Year	28b. Time o		8c. Injury Work	at		28d. Describe h			,
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Division	r Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Pla	ace of Injury - A	t home, farm, st	reet, factory	, office			28f. Location (S City or Town		mber or Rura	l Route Number,
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	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	edical	(Uneck only 2 Medical	ng Physician: To Examiner: On the	e basis of exam	knowledge, dear	h occurred a	at the tim	e, date and	d place, a	and due to the c	ause(s) and i	manner as st	ated.
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	1741		30. Name and address of person	who completed c	ause of death (Item 23a) (Type	Print)	50	11	Nine.	Alla	117	Y N	AD DIME
	- 0		31. Date filed (Month, Day, Year,	1000	2. Registrar's Si	gnature	00	70):UV	110	THUE	H	MI.	11/21010
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		•	For State Registrar	State of Mar		artment of Firtificate of			ene2 () () 5	20401
	0		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio			Francis	John Buhr			June 12,	2005	8:00 A M
	Examir	ier	4a. Facility Name (If not institution, give 14626 Stottlemyer			Smith	_		4c. County of Dea	
	Funeral Director		220-18-0440	x 7.Age (☐M 2☐F	In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) C	rthplace (State or Foreign country) aryland
	land		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary Fired a	ţō	Md. Fred	lerick	Smit	hsburg				1 ☐ Yes 2 🔀 No
	h the	Director	10e. Street and Number			10f. Zip Code	702	10g	. Citizen of What C	country?
	23a c	aiD	14626 Stottlemyer	Rd.			783		U.S.	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Items 23a or 28a-1 show it If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Exatti we final be multiped at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
5-0	72 ho	eted	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king 16	b. Kind of Business	s/Industry
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Ž	and 2 nalth a 127 lt		John Buhrman (Son))			myer Rd.	Smithsbur		
ore	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		20b. Place of Dispersion Carfield	osition (Name of matory or other place IIIn 1 F. ed	(a)	16	c. Location - City o	
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	-		23a Part1. Enter the disease, or comp	lications that caused thene cause on each line.	e death. Do not en		1			Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	cons - ruence of):	1 +	0	sease		
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9	ntificat ng phy as th		PECCHAPE.						- 17	
Вох	death certificate be executed e attending physician and of for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pregnanc	/		23d. Date of de Month	elivery Day Year
0	the atte	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death 5 (Other (specify)				22,
Р.	ac ac	Phy	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	anderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ds,	Se G							1 🗆 Yes	2□No ,3□F	Probably 4 Unknown
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Re	The law ate has b page 2 sl	duic						autopsy performe	d? death?	completion of cause of
Vital	sician: Th certificate irector, pag	e C	25. Was case referred to medical				26. Place of Dea	th (Check only one)	ENO 1010	3 20110
Į V	y s	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗌 Inpatient	2 ER/Outpatie	nt 3□ DOA Ott	ier: 4 🗌 Nursing H	ome 5 Resident	ce 6 □Other (Sp	ecify)
n of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time (Wo	k ?	28d. Describe how	injury occurred	
sio	Attending r death. sctor: After oy the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No	OOL Leasting (Ctm	at and blumbaras f	David Barris Moreland
Division	or Attenation after death Director:	ertification:	4 Homicide determined	building, etc.	r - At home, farm, st (Specify)	reet, factory, office		City or Town,		Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		ysician: To the best of tiner: On the basis of e and manner state	xamination and/or in					
	To the within 2 To the complete	Me	29b. Signature and title of certifier	fairl m	had	29c. Licens	06039		Date signed (Mor	oth, Day, Year)
-	3		30. Name and address of person who of	completed cause of dea	ith (Item 23a) (Type	, Print)	Opa"	retida	MD 21	740
	St	ate	31. Date filed (Month-Day, Year)	32. Renistrar						
	Regist	rar	JUN 182	1005 Slean	JH I	acet i				

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ORIGINAL

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			jiene og. No.2		20402
	Physic /Medi		Decedent's Name (First, Middle, La MAGGIE ELIZAE	,				2. Date of Dea Month JUNE		Year 5	3. Time of Death 4:25A
	Exami Funeral Director			HOUSE	(In yrs. last birthday)	4b. City, Town, of MT . A If Under 1 Year Months Days		8. Date of Birth (Month, Day	4c. County FRE	of Death DERI	
	p >	tor	Usual Residence of Decedent 10a. State 10b. County MD FREDE		93 Oc. City, Town or Lo			FEB 7	1912	M	D. Dd. Inside City Limits
	th with the 23e or 28	al Direc	10e. Street and Number 908 PINE AVE.			10f. Zip Code 2 1 7	701	1	0g. Citizen of V	Vhat Count	try?
900	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow he Madical Examiner must be natified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Et Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		e - America k, White, e	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f ehov other treumetic event, I're Madical Examiner must be natified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired STMASTE	during most of work. d)	ing	16b. Kind of Bu		ustry L SERVICI
Maryland	should be fill and Mental His marked oth	To Be	17. Father's Name (First, Middle, Last FRANCIS DAVIS)			18. Mother's Name		laiden Sumam	9)	
Baltimore, Mar	80		19a. Informant's Name/Relationship (OLLIE TAVENNE 20a. Method of Disposition 1 Burial 2 Cremation 3 Companion 5 Other (Special	R/DAUGHTE	R 908	PINE AV	(e)	DERICK,	MD 2	2 1 7 0 1 City or Tov	vn, State
Baltii	permit. Pag Department Importent: h any injury o		21. Signature of Funeral Service I cel			Name and Address		HOME			
OF HERE	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	aDue to (or as a d	consequence of):	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death Yylaw
38760,	icate be executed physician and s the burial-transit	dical Examine	If any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):						
.O. Box (that the death certifics ed by the attending ph detached for use as t	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 □ Yes 2 ☐ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery	/ Day Year
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Division	itel or Atteners after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	et, factory, office	2	28f. Location (Stre City or Town,	eet and Number State)	or Rurai F	Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	fedical	one)	ysician: To the best of n liner: On the basis of ex and manner stated	ammation and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	ise(s) and mani e and place, an	ner as stated due to the	ed. ne cause(s)
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•	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 2	32. A gistrar's	300 Signature	west	97257	tra	Peric	K)	MD

Please Type or Printiff Black Indelible ink Ensure All Copies Are Legible. Amend Item 95 Start 1 (1997) His day of the Start	William Edward		Francia an Duinfalà I	51-A-1-1-1-10				
Projection Filtraria		Amend Item #5	Per FH 6852	2/27/06 JE	ole ink. Ensure	Mental Hy	Are Legi	ble.
Figure 10 200 To the property of the property		1- State Amend Item 18 Registrar amend item	RUnpend Item 2	23a&27 per 6 8 <i>59</i> 165	me 6846 8-3- aim of Death	-05 tas	Reg. No. 1	We Was
## Financial Diversion Financial Diversion Communication of the property Communication	Physician	Decedent's Name (First, Middle, Last,)			2. Date of De	ath	3. Time of Death
Control of Director Control of Director	/Medical					June 10	0, 2005	2:00 p. ^M
Purposed Department of Departm	Examiner					ıtn		
Part Command	Funeral	5. Social Security N 6. Sec	7. Age (In yrs.	last birthday) If Ur	ider 1 Year If Under 24 Hr	s. 8. Date of Bin	m !	9. Birthplace (State of Foreign
Month Mont	10	222-10-4920	7M 2D1 /1	Yrs.				Delaware
10 Name of Section No. 12 No.	ryland							10d, Inside City Limits
10 Name of Section No. 12 No.	he Ma		r					
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23 Part. Enter pt finases or complications that death. Do not enter the model of yen, such as cardiace or respiratory areast, indicated between finance of the model of yen, such as cardiace or respiratory areast, indicated between finance of the model of yen, such as cardiace or respiratory areast, indicated between finance of the model of yen, such as cardiace or respiratory areast, indicated between finance of yen, such as cardiace or respiratory areast, indicated between finance of yen, such as cardiace or respiratory areast, indicated between finance or yen, and the past 12 months? **Hypertensive Atherosclerotic Cardiovascular Disease**	212 d withing a withing a single of the man	Elementary/Secondary (0-12)	College (1-4or 5+)				Commiss	ion on Aging
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23 Part. Enter pt finases or complications that death. Do not enter the model of yen, such as cardiace or respiratory areast, indicated between finance of the model of yen, such as cardiace or respiratory areast, indicated between finance of the model of yen, such as cardiace or respiratory areast, indicated between finance of the model of yen, such as cardiace or respiratory areast, indicated between finance of yen, such as cardiace or respiratory areast, indicated between finance of yen, such as cardiace or respiratory areast, indicated between finance or yen, and the past 12 months? **Hypertensive Atherosclerotic Cardiovascular Disease**	tim(Pag tment tmnt: Jury o	4 □Donation 5 □ Other (Specify)	EVE		•	E		
23a Part. Enter you finate a complications the forested seath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Introduction and Coast of Coast Open Season Introduction In	Ball permit Depar Impor	21. Sign (tre) of uneral cervice Licens						
Impreciate Cause (Final Impr		23a. Part1. Enter the disease or complished or heart failure. Ust only of	ications that caused the death					Approximate
State	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	e Atheroso				Onset and Death
1 Action 1	68760, difficate be exect g physician and as the burial-tire	resulting in death) Last	Due to (or as a consequent	uence af):				
1 Action 1	.O. Box the death cert solve the attending solve to use as	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2□Fetal 4□Pregnant at time of de	I death 3 Ectopic				
1 Action 1	rds, P quires that on signed b uid be deta	Part II. Other significant conditions con	ntributing to death but not rest	ulting in the underlyin	g cause given in Part I.			
1 Action 1	eco lawre as bee 2 sho							Vere autopsy findings available
1 Action 1	The Tage had page					perfor	med? d	eath?
1 Action 1	Vita vician certifican rector,	examiner?	lospital:					
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) TABLE 31. Date filed (Month, Day, Year) 5 2005 32. Fegistrar's Signature 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number OCME June 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TABLE 31. Date filed (Month, Day, Year) 5 2005 32. Fegistrar's Signature	g Phya gr this eral di	27. Manner of Death	1 inpatient 2	28b. Time of	DOA 4 Nursing I	Home 5 Resid	ence 6 vOthe ow injury occurre	or (Specify) At scene
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number OCME June 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TABLUCAH TU 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 2005 32. Fegistrar's Signature	sion ending sath. or: Afte he fun		(Month, Day Year)					
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	Divis tal or Att rs after de al Directe ed in by th	data-minad	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fact v)	tory, office	28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TABLE 31. Date filed (Month, Day, Yaar) 5 2005 32. f egistrar's Signature	he Hospi in 24 hou ha Funer pletely fill edical	(Check only 2 Medical Examin	ner: On the basis of examinal	wledge, death occurr tion and/or investigati	ed at the time, date and plac- ion, in my opinion, death occ	e, and due to the durred at the time, o	ause(s) and mar late and place, a	nner as stated. nd due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAISIUCAH TU 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 5 2005 32. Fegistrar's Signature	To To To To M	29b. Signature and title of certifier	10 10			2	-	
State 31. Date filed (Month, Day, Yaar) 5 2005 32. Fegistrar's Signature		30. Name and address of person who co	mpleted cause of death (Item			Baltim		100000000000000000000000000000000000000
	_	31. Date filed (Month, Day Year) 5 20	32. Legistrar's Signa		V		,	

Kenneth Orville Durst Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item #8 per th 8845 7/14/05 JH
State of Maryland 7 Department of Health and Mental Hygiene 05-03943 crn 1- State Unpend Item 23a&27 per me G844 6-12-05 tas Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Veal 12:50 A M 09 June 2005 /Medical Kenneth Orville Durst 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 964 Taylors Island Road Madison Dorchester 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**8** M 2□ F 56 Director 219-56-9819 Yrs Pennsylvania Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f shov tre Medical Exerciper must be notified at Director MD 1 Yes 2 No Dorchester Madison 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 964 Taylors Island Road 21648 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Building Construction marked other ment of Health and Mental Hy, ut: if item 27 is marked and y or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: if item 27 is marked c any injury or other traumatic eve since. Wilbert Durst Verta Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Durst/Brother P.O. Box 209, Salisbury, PA 15558 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Grantsville Cemetery June 13, 2005 Grantsville, MD 21. Signature of Furreral Service Licensee Newman Funeral Homes, P.A. 22. Name and Address of Facility P.O. Box 275, Grantsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death **Physician** Acute Thrombosis Coronary Artery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ło in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Probably 4 Sunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 1. Yes 2□ No 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Certification: To 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient Cthen 4 Nursing Home 5 Residence 6 Nother (Specify) at scene 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME

State Registrar

DHMH 17 Rev 1/2001

AWA

RUBIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street

MO

June 09, 2005

Baltimore, Maryland 21201

		ı	For State Registrar	State of M	laryland / D		rtment tificate				iene eg. No. 🦙 🐴	, en		
	Physici /Medic		1. Decedent's Name (First, Middle, Las James A. Davi							2. Date of Deat		Year	3. Time of 3:08	
	Examir		4a. Facility Name (If not institution, give Prince George	street and number, S HOSP	ital			wn, or Loc verl	ation of Death Y		4c. County Prin		Georg	e's
E	Funeral Director		5. Social Security Number 156-34-5189 6. Se	x 7. Aq DMM 2□F 5	ge (In yrs. last birtl 8 Y	hday) (rs.	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Birth Dec . 05	, 46	9. Birth	place (State or intry) antic	r Foreign City
	Maryland f ehow	tor	Usual Residence of Decedent 10a. State C . 10b. County		10c. City, Town Washi							1,	10d. Inside Cit	y Limits
	ath with the Marylan 23a or 28a-f show ust be notition	I Director	100357000 ETY Place	S.E. #	201		10f. Zip C	^{ode} 019			0g. Citizen of V		intry?	
920	after des	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	? No		/as Deceder Yes, specify		nic Origin? (Sp exican, Puerto pecify:	ecify Yes or No- Rican, etc.)	Blac	e - Amer k, White		
21215-0036	within ane. than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or		(Give k	ent's Usual rind of work O NOT use OE NE	done durino	g most of work	ing	Self		oloyed	
Maryland 2	al Hyg I otha vant,	To Be C	17. Father's Name (First, Middle, Last) James Davis					18.	Mother's Nam Barbai	e (First, Middle, M ra Ring	Maiden Sumam gold	ie)		
			19a. Informant's Name/Relationship (7 Brenda E. Sar	ope, Print) Iderlin Sister	195	Mailing 03	Address (ecat	ur Ave	Plea 08	santv 232-3	State Zi L 11 E	^{Cod⊕} J.	
Baltimore,	Page ment ant: If ury o		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify,		20b. Place of cemetery Atlan	Dispos y, crem iti(ition (Name atory or oth C Cit	of er place) ycem	et6/1	1 / 0 5	20c. Location - Pleasa			NJ.
Balti	permit. Departr Imports any inje		21. Signature of Funeral Service Licens	Rok	many	\22.	Name and Robin	Address of	Funera	al Home Washin	1313 aton.	6th	st.	N.W. 01
68760,	/Medical be executed / Medical Examiner Shysician and Shys	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CARDID Due to (or as Due to (or as CONGES	CARDIAC s a consequence o MY OPATH s a consequence o STIVE HE s a consequence o	of): IY on): AR	T FA						Onset and D	eath
Box	attending for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic preg Other (spec				23d. Dat		,	e ar
ds, P.O.	juires that the de r signed by the lid be detached		Part II. Other significant conditions co			the und	derlying cau	se given in	Part I.		acco use contr			
I Reco		Completed by	DIXBETES MELLIT	rus						24a. Was an autops perform	y ned?	rior to co leath?	opsy findings a ompletion of ca	vailable use of
Division of Vital Records,	ding Physician h. After this certifi funeral director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpati 28a. Date of Inj (Month, Da			_		☐ Nursing Ho	n <i>(Check only onl</i> me 5 ☐ Reside 28d. Describe ho	nce 6 Othe		fy)	
Divis	al or Attands after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	ijury - At home, fari tc. <i>(Specity)</i>	m, stre	et, factory, o	office		28f. Location (Sti City or Town	eet and Numb , State)	er or Run	al Route Numb	oer,
	To tha Hospital or Al within 24 hours after of To tha Funaral Dirac completely filled in by	ledical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example (Check only one)	rsician: To the best iner: On the basis of and manner s	of examination and	death Vor inve	occurred at estigation, in	the time, da	ate and place, n, death occur	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as s	stated. o the cause(s)	
).	To that within 2. To that complete	W	29b. Signature and title of certifier					006	/ -		od. Date signed			
f	(4)		30. Name and address of person who de DR EDWALD K. SM	ompleted cause of	death (Item 23a) (1	Type, P	rint) TAL	DRIVE		PHEVERL	Y, MD	21	185	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 7 2005	2. Regist	rar's Signature	Car	17.1							

State of Maryland / Department of Health and Mental Hygiene U U 🕽 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner hestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. Month, Day, Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number **Funeral** 216-52-251 1 M 2 K F Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28a-f show other treumatic event, the Medical Evanther must be notified at Ken 1 Yes 2 No Funeral Director 10g. Citizen of What Country? U.S.A ervi 110 tonest death 1 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No lf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or iten any injury or other treumatic event, it a Mexical Examination once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Un Known 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/657 19a. Informant's Name/Relationship (Type, Print) Husbana 10698 Chesterville Forest Rd Milling for ID 20c. Location - Tity or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State June 14, 2005- West Chester * 4 ☐ Donation 5 ☐ Other (Specify) of Delanque 21. Signature of Funeral Service Conses 22. Name and Address & Facility This Ki Ke, Wilmstaglies 23a. Part1. Enter the disease, or committations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only opercause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) R dem A **Physician** /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HARTU EDEMA. SPLENC EDEMA 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funerel Director: After atural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Idedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of MI no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person CHESTERM Md 2/010 120

State Registrar

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:52 2005 June Eshbaugh Helen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Brunswick 202 7th Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2X F 217-09-5369 Director July 5, 1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evarinas translative rediffied at Maryland Frederick Brunswick 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 202 7th Avenue 21716 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status ☐Yes 2 [X]No f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Thompson Virginia Hul1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 200 Wintergreen Lane, Brunswick, MD 21716

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or To Mike Eshbaugh/ Son 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ō permit. Page Department of Important: if any injury or 6/4/2005 Union Cemetery Lovettsville, VA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee Function 1100 N. Maple Avenue, Brunswick, MD 21716 23a. Part I. Enlitt the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure **Physician** Adult months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anorexia Sequentially list conditions, if any, leading to anni solution cause. Enter Underlying Cause (Disease or injury Examiner Dua to (or as a nonsequence of) The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant been signed by the atter should be detached for u 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate 1 🗌 Yes 2€No Attending Physicien: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 sesidence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation s after death 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 To the Hospitel within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO/M.D. D47169 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9th AVE, BRUNSWICK, MOZ1716 CHAN-HING HO 610 /MID. 31. Date filed (Month, 32. Restrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registration ITFM #4 1. Decedent's Name (First, Middle, Las	a PER PHY G844					Reg. No.		
	Physic /Medi		Presley R. Eva	•				2. Date of De Month May	Day	005	3. Time of Death 3:25 P M
7	Exami		4a. Facility Name (If not institution, give	e street and number) EMENT COMMUNIT	Y		r Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Security Number 1	er		If Under 1 Year Months Days	Itchellv: If Under 24 Hrs. Hours Min.	111e 8. Date of Bin (Month, Da June 2	Pr (h) (9, 1909	ince 9. Birthp Coun Vir	George's place (State or Foreign rty) ginia
	yland Jow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	h the Marylan or 28a-f show	ctor	Maryland Prince	George's		Mitche	llville				1 X Yes 2 □ No
	th with th	al Director	10e. Street and Number 10450 Lottsfo	ord Road		10f. Zip Code	20721		10g. Citizen of V	What Coun	•
920	hours after death with the Maryland tural; or items 23a or 28a-f show af Exantimetry stat be mutified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 \(\) No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2፟ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, o	
21215-0036	n 72	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life. L		ation during most of work 1) acher	ing	16b. Kind of Bu		,
	e filed within al Hygiene. I other than vent, It e M	a)	17. Father's Name (First, Middle, Last)	<u> </u>		re	18. Mother's Nam	e (First, Middle,		vernm	ent
Maryland	2 should be and Mental Is marked o	To B	Sam Evans						11ie (U1	•	m)
/au	2 sho and I Is me		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	ar, City or Town,	State, Zîp	Code)
Baltimore, 1	ges 1 and it of Health If item 27 or other t		Junius Jeffries/B 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	20b. Pla	netery, crem	sition <i>(Name of</i> natory or other plac		Date	20c. Location -		
Baltin	permit. Pa Departmen Important: any injury once.		21. Signature of Fulleral Service Licens	A-1		. Name and Addres	ss of Facility S	tewart	Funeral	Home	
	Physician		23a. Part 1. Pater the disease, or comp shock of heart failure. List only of Immediate Gause (Final disease or condition	lications that caused the death. one cause on each line. Aspiration		er the mode of dyin					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		umonza					7 Days
	3	ner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Dysphagia Due to (or as a conseque				· · · · · · · · · · · · · · · · · · ·			
68760,	rtificate be executed ng physician and as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Organic E Due to (or as a conseque		Syndrome					
P.O. Box 68	The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	of deliver	ry Day Year
	uires that signed t	by	Part II. Other significant conditions co Acute Renal			derlying cause give					e cause of death?
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/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only or	10)		
of	Phys this al dii	P.	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatient 2 EF		3□ DOA Othe	or: 4 Nursing Hor	me 5 Reside	ence 6 Othe	r (Specify)	
lon	th. : After s funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work	at ? ′es 2 ⊡No	28d. Describe h	ow injury occurre	ed	
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location (Si City or Town	treet and Numbe n, State)	r or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 15 Certifying Phy (Check only one) 2 Medicel Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the timestigation, in my op	e, date and place, a inion, death occurre	and due to the ca	ause(s) and mar ate and place, a	ner as sta	ted. the cause(s)
	To the within 2.		29b. Signature and title of certifier			29c. License		2	9d. Date signed	(Month, D	ay, Year)
0			· WAR	3		1	7603		June	2, 20)05
K	(4)		30. Name and address of Aerson who ce					UD 0.2.5			
F	Sta	е	WIIIam I 31. Date filed (Month, Day, Year) IIIN 0 7 2005	DuBoyce M.D. 2. Registrar's Signatur	4000 N		ille Rd.,	#B216,	Bowie,	MD	20/16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Of Waryta State Registrar AMEND#20bperrFH6/9/05, EMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Month 3. Time of Death Day Year tacchina u, Columbus 6:41 AM June 5 2005

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or Itams 23a or 28a-1 show any injury or other traumatic avant, I'll Medical Exame at must be multipled at once. Baltimore, Maryland 21215-0036 Priysician

Physician

Examin

Funeral Director

/Medical Examiner	eľ
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Yethe Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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er	4a. Facility Name (If not institution Washington Adven	n, give street and n	ontal			naPar	-1_		Montgo	
	5. Social Security Number 578-03-0805	6. Sex 1.23 M 2.☐ F	7. Age (In yrs. 92		Months Days		Min. 8. Date of B (Month, I OCt. I	Birth Day, Year)	912 Wa	Birthplace (State or Fo Country) ashington,
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Director		ce George	's Hy	yattsv	'ille			,		1 ☐ Yes 2x
늞	10e. Street and Number				10f. Zîp Code			10g_Cit	tizen of What	Country?
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Be C	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Midd	le, Maiden	Sumame)	
ToB	Carlo Angelo	Facchina				Cr	istina Ag	nolut	tto	
_	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mai	ling Address (Street					, Zip Code)
	Florence Faccl	hina/ Wif	е	672	1 Raydale	Road.	Hvattsvi	11e.	Marv1=	and 20783
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	Place of Disp cemetery, cre	oosition (Name of ematory or other place 's Cemete	ce) (June 8,9	20c. Lo		or Town, State
53. ;	21. Signature o Funeral Service		1	F	Pancis J. Co Univer	ss of Facility	ns Funera	1 Hor	ne Inc	
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	SHOOK, OF HOUR TAILUTO. LIST	one cause on	each line.	III. DO HOL BI	nter the made of dyir	ig, such as ca	rdiac or respiratory	anest,		Interval Between
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State Registrar 0 6 2005

			1- State of Maryland / Department Certificate		Mental Hyg	_	5 204
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Y	3. Time of Death
1	/Medi	cal	Rev. James P. Finnegan, O.S.F.S		June	12 20	05 1237 P M
	Exami	ner		own, or Location of Death		4c. County of	
	F		Annecy Hall 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8. Date of Birth	Cecil	
	Funeral Director			Days Hours Min.	8. Date of Birth (Month, Day, May 8,		. Birthplace <i>(State or Foreig</i> <i>Country)</i> Pennsylvania
	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show fre Mcdical Examinati, ust be multiped at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Marylar 28e-f show	ctor	Maryland Cecil Childs				1 ☐ Yes 2 🏋 No
	or 28	Funeral Directo	10e. Street and Number 10f. Zip C	ode	1	0g. Citizen of Wha	at Country?
	ath w	ra	1120 Blue Ball Road 219)16		United	States
	er de Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, specific	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	rs aff	by F	1 Nover Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes Year or Dates:	No Specify:		Specify:	White
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Maryland	d 2 should be filed within th and Mental Hygiene. 7 is marked other then "treumetic event, I're Ma	0.3		Street and Number or Rura			
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ita		BeC	25. Was case referred to medical	26. Place of Death		₽ No 1□'	Yes 2 No
of V	S 0 7	To	examiner? 1 Yes 2 76 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Hon			Specify)
			27. Manner of Death 1 1 1 1 1 2 1 2 2 2 2 2 2 3 2 2 3 2 3 2		28d. Describe hov		
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
-	I or Atten after deat Director: I in by the	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice 2	28f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,
	Hospitel (24 hours at Funerel Distely filled i		29a. Certifier 117 Certifying Physicien: To the best of my knowledge, death occurred at the	4			
	To the Hospitel or Attenwithin 24 hours after dealt To the Funerel Director: completely filled in by the	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurre	and due to the car ed at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To To	Σ		icense number	_	d. Date signed (M	, ,
•			100 Ch. Har Du M	DH00543	80	June 13	2005
_	10		30. National address of person who completed cause of death (Item 23a) (Type, Print) Chi	Sistine E.K.	Horah, (9)//	D.O.	
	Sta Registr	te ar	31. Date filed (Month) Pan Year) 32. Posistrar's Signature				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mi	aryland / Depa <i>Cel</i>	artment of H rtificate of L			ene g. No. 🤈 👌 👝 🎮	
	Physici /Medic		1. Decedent's Name (First, Mid	dle, Last) MARY ROSE	GORDON			2. Date of Death Month JUNE		3 Time of Death
	Examir		4a. Facility Name (If not institut	ion, give street and number)		4b. City, Town, or	Location of Deati		4c. County of Death	111.03
и			WASHINGTON	ADVENTIST HOS	SPITAL	TAKON	IA PARK		MONTGON	ŒRY
	Funeral Director		5. Social Security Number 165–14–9443	6. Sex 7. Ag	e (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG. 18	9. Birth Cou.	place (State or Foreign ntry) PA.
	ryland thow		Usual Residence of Decedent 10a, State 10b, Coun	ty	10c. City, Town or Lo	ocation	-			10d. Inside City Limits
	e Ma la-1 s	cto	MD. MON	TGOMERY		TAKOMA I	PARK			1 x Yes 2 □ No
	th th or 28	ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	238 238	a	7525 CARE	OLL AVE.		209	12		U.S.A.	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28a-f show other treumatic event, the Madical Examiner must be neithed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorce	If Yes, Give	1	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	in 72 ho n "netur	Completed	(Specify only high	ent's Education lest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ntion luring most of wor	rking	6b. Kind of Business/In	
	filed with Hygiene. other ther		Elementary/Secondary (0-12 8 17. Father's Name (First, Middle)+)	SALES CLE	RK	ne (First, Middle, Ma	HECHT CO).
Maryland	2 should be tand Mental I is marked o	To Be	JOHN		OAN			LLY	UNK.	
lar	2 sho and is m		19a. Informant's Name/Relation	nship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Ru	ıral Route Number, (City or Town, State, Zip	Code)
	1 and 2 Health tem 27 i	1		KOSSMAN/DAUGH		OX 81, BE	LTON, SC			
Baltimore,	m O L		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other	n 3 □Removal from State (Specify)		sition (Name of natory or other place CREMATOR		-2005	RIVERDALE	
Balt	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service	11.0	22 CH	. Name and Addres	s of Facility	ME & CREM	MATORIUM,P.	Α.
	#		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final		the death. Do not enti	er the mode of dying	, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a SEPTIC Due to (or as	SHOCK a consequence of):		-			
H		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		ARTERY D a consequence of):	ISEASE				
	cuter nd ransi	Examiner	Cause (Disease or injury that initiated events	c. THYROID	DISEASE					
68760,	ficate be executed physician and is the burial-transit	Aedical Ex	resulting in death) Last		a consequence of): SEPTECIMI	A				
.O. Box	death certi e attending id for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	quires that n signed t uld be det	by	Part II. Other significant condi	tions contributing to death be	ut not resulting in the ur	nderlying cause give	n in Part I.		cco use contribute to th	
al Record	: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was an autopsy performe	prior to cor	psy findings available npletion of cause of 2 \square
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Hospital:		Other	r	th (Check only one)		
of	ing Phys After this uneral di	tion: To	1 Yes 2X No 27. Manner of Death 1 Xatural 5 Pend 2 Accident inves	28a. Date of Injur	nt 2 ER/Outpatient y 28b. Time of Injury	28c. Injury Work	at	ome 5 Residence 28d. Describe how	ce 6 □Other (Specify injury occurred	<i>'</i>)
Division	tel or Attending s after death. el Director: After ed in by the fune	Certification	3 Suicide 6 Could	I not be	ury - At home, farm, stre			28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospitel of within 24 hours all To the Funerel D completely filled is	edical (29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best of I Examiner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the time restigation, in my opi	e, date and place, inion, death occur	and due to the causered at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certif	er		29c. License	number	29d	. Date signed (Month, I	Day, Year)
}	r		> Strue				6998		JUNE 2, 20	05
	1		30. Name and address of perso			,	mourr	.m. 00=0		
	Sta Registr	200	STEVEN TEE 31. Date filed (Month, Day, Yea		HAMILTON :	ST., HYAT	TOATPPE	MD. 20/8		

Allen 05-039	Lee Ha 985	wk	Unpend Item 23a, p	e or Print in E	Black Ing	delible	<u> </u>	Ensure tas	e All	Copies	s Are	Legib	le.		
NJM	9		For State Amend item #1	ate of Marylan 9a per fh/v	d/Depa vichd/	artmen	t of H Ω5-/ _f d/	ealth ar b aath	nd Me	ental Hy		201	1 1	0 01	1 0
			Decedent's Name (First, Middle, Last)	1		tinoati	0 01 2	Jean	- :	2. Date of D				3. Time of I	Death -
	Physici /Medic		Allen Lee Hawkins		1				_	June	1	0 20	^{'ear} 05	1545	М
-	Examin	er	4a. Facility Name (If not institution, give street 733 South Division	•	t. 6		Town, or lisb	Location of I	Death		4	c. County of Wicom			
7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i	ast birthday)		1 Year Days	If Under 24	Hrs. 8	B. Date of Bi (Month, D	irth la <i>y, Y</i> ea			ace (State or	Foreign
	Director		219-62-8010 TMM Usual Residence of Decedent	50	Yrs.				J	uly	11,	1954	Mar	ýland	
~ /	Maryland f show	<u>.</u>	10a. State 10b. County	10c. City	y, Town or Lo	cation							10	d. Inside City	
	28a-f	ecto	Maryland Wicomico	Sa	lisbu	ry 10f. Zip	Code				100.0	Citizen of Wh	at Count	1 X Yes	2 No
	death with the rms 23a or 28a	Funeral Director	733 South Divisio	n St. Apt	. 6		804				US		u. 00um	.,, .	
	er dea	uner	A	/as Decedent Ever in U. rmed Forces?		Vas Deced Yes, spec	dent of Hi cify Cuba	spanic Origin n, Mexican, F	n? (Spec Puerto R	ify Yes or N ican, etc.)	0-	14. Race - Black,	America White, e		
036	hours after ural', or Ite	þ	If	☐ Yes 2 🙀 No Yes, Give ear or Dates:	1	□ Yes	2 ¹ No	Specify:				Specify:	Mb	ite	
5-0	72 hours "natural",	leted	15. Decedent's Education (Specify only highest grade com	n npleted)	16a. Deced	lent's Usua kind of wo	al Occupa rk done d	ation furing most o	f working	7	16b.	Kind of Busi			
21215-0036	withir sne.	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)		tend)			Ba	arten	ding	g	
pu	es 1 and 2 should be filled vol Heelith and Niental Hygie filtam 27 is marked other filtam 27 is marked other fir other traumatic evant. It	Bec	17. Father's Name (First, Middle, Last) Roger Evans					18. Mother's Mary	Nama (First Middle	, Maide	n Sumame) een			
Maryland	should and and and and and and and and and an	ဥ		rint)	19b Mailin	a Address		and Number o						Code	
Ea	and 2 selth ar		19a Informani's Name/Relationship (<i>Type, P</i> Della M. Willey/ni	ece		_		Dr.,						0000)	
ore	Pages 1 and of He not of He not of He not of He not of He not of He not of he not of he not h		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Remove	C	lace of Disposemetery, crem	natory or o	ther place	e)	Da			Location - Ci lisbur			
			' 4 □ Donation 5 □ Other (Specify)		00										
Ba	permit. Departr Imports any inju	3	Daire H.	Domosa	5P H	ollow Ol Sr	ay F	uneral III Ro	Hor.	ne Pro Salisk	ury	, MD 2	ASS 1804	l	LON
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death use on each line.	n. Do not ente	er the mod	e of dying	g, such as ca	rdiac or	respiratory a	arrest,			Approximate Interval Betw Onset and De	een eath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	therosclero		rdiov	ascu	lar Di	seas	se			-		
	Examiner		Sequentially list conditions b.												
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entry Urdary ing Cause (Disease or injury	Due to (or as a consequ	uence of):										
o,	an and rial-tran		that initiated events c c	Due to (or as a consequ	uence of):										
9289	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	d												
Вох 6	certific nding puse as	n/Me	IF FEMALE: 23c. If 23c. If 23c. If 1	yes, outcome of pregna								23d. Date of	of deliver	v	
). B	s death he atte ed for	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	☐Live birth 2 ☐ Fetal ☐ Pregnant at time of de ☐ Unknown		Ectopic pri Other (sp						Month		Ďay Ye	ar
P.0	that the de led by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions contribut	ting to death but not resu	alting in the un	nderlyina c	ause give	on in Part I.		23e. Did	tobacco	use contribu	ute to the	cause of de	ath?
rds,	w requires tha been signed I should be det	Completed by	Diabetes Mellitus						_	10	Yes :	2□No 31	□ Proba	bly 4 □Ur	known
eco	e law requ has been ge 2 should	plet								24a. Was		24b. We	re autop	sy findings av	/ailable
a R	That are									perfe 12 ves	ormed? 2 □ N	dea	th?	2□ No	
Division of Vital Records,	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner? ¹X Yes 2 □ No Hospit	al: 1 ☐ Inpatient 2 🗀 I	ER/Outpatient	3 DO	A Othe	26. Place of 4 □ Nursi				6 X X ther	(Specify)	Scene	e
ם ס	fter nen	on: 1		a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work	at ?	28			ury occurred	,,/		
isio	Attending r death. actor: After y the fune	ficati	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could nice be 28	e. Place of Injury - At ho	me, farm, stre	M eet factory		fes 2□No		f. Location /	Street a	and Number	or Rural	Route Numbe	A <i>r</i>
ο	tal or safter safter at Dira	Certification:	4 Homicide determined 20	building, etc. (Specify)	ot, raciony	, 011100			City or To				1100101101	o,,
	To the Hospital or Attendit within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physicier (Check only one) 1 Medical Exeminer:	: To the best of my know on the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred estigation,	at the tim in my op	e, date and pointion, death	occurred	d due to the l at the time,	cause(date ar	s) and mann nd place, and	er as sta I due to t	ted. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	To marino statos.		29c	License				29d. D	ate signed (A	Month, D	ay, Year)	
			· Calricella	X CK			OC				Ju	ne, 11	, 20	005	
			30. Name and address of person who comple	ted cause of death (Item	23а) (Туре, Г		Penn	Stree	t E	Baltim	ore,	Mary	land	21201	
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signat	ture	-		 							
	Registr	ar	JUN 1 5 2005	Blown	J. 14	porte	_								

				State of	of Marylan	-	artment rtificate				,	giene Reg. No	NE	201.12
	Dhusia		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath	V	3. Time of Death
	Physic /Medi		Mary Elaine H	utzel							June 1	2, ^D 2005	Year	8:45 a.m.
	Examir	ner	4a. Facility Name (If not institution	n, give street and nu	imber)			4	b. City, To	wn, or Lo	ocation of Deatl	4c. Count	y of Death	
			Goodwill Mennon 5. Social Security Number		7 4 //		If Under	1 Voor	Gran If Under			Garr		
80	Funeral Director		211-12-9510	6. Sex 1 □ M 2 🛛 F	7. Age (In yrs. 86			Days	Hours	Min.	8. Date of Bir (Month, Da March	iv, Year)	Counti	sylvania
			Usual Residence of Decedent		00						rial CII	1/1/1/	r emis	Syrvania
	larylan ahow		10a. State 10b. County		10c. City	y, Town or Lo	cation						10	d. Inside City Limits
	Ba-fa	Ş	PA Somers	et	Sal	isbury								1A⊡Yes 2□No
	or 2	Dire	10e. Street and Number				10f. Zip	Code 558				10g. Citizen of		y?
	eath v	eral	268 Ord Street	10 Mac Dac	adont Frontia III	0 40.1						US		
21215-0020	be filed within 72 hours after death with the Maryland nat Hyglene. Id other than "natural", or items 23a or 28a-f ahow event, the Madical Examiner must be notified at	by Funeral Director	11. Maritał Status 1 □ Never Married 2 □ Mari 3 □ Widowed 4 □ ☑ Vivorced	ied Armed Fo	2 X No ve	l:	vas Decede fYes, speci I□Yes 2		Ispanic Ori In, Mexicar Specify:		ecify Yes or No Rican, etc.)	Bla Specif	ce - America ck, White, el y: Whit	tc.
9	2 hou	ted	15. Deceden	t's Education		16a. Deced	lent's Usual	Occupa	ation			16b. Kind of B		
2	C " (N)	Completed	(Specify only higher Elementary/Secondary (0-12)	College (kind of worl OO NOT use		during mos !)	t of work	ing			
12	filed with Hygiene. other than	ပ်	8			Self-	Emplo	yed				Person		Giver
Maryland	should be filed withind Mental Hygiene. marked other than Imatic event, the Mental Men	Be	17. Father's Name (First, Middle, Walter E. Hersh	·							e (First, Middle, Hotch	Maiden Sumar kiss	ne)	
ary	d 2 should th and Men 7 Is marke traumatic	2	19a. Informant's Name/Relations			19b. Mailin	a Address	(Street a				er, City or Town	State Zin C	Code)
	12 ha		Austin C. Hutze	l Jr./ Sc	n				_		cy, PA	15558	, <u>-,</u>	,
Baltimore,	8 5 = 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Momental from	^/	ace of Dispos	sition (Name	e of her place	e)		Date	20c. Location	City or Tow	n, State
Ĕ	nit. Pages artment of f ortant: If ite injury or of e.		4 ☐ Donation 5 ☐ Other (S			isbury	Ceme	tery	7	Ju	ne 14,	2005 Sa	lisbur	y, PA
3all	pemit. Page Department Important: If any injury or once.		21. Signature of Funeral Service	\bigcap	,	22	. Name and	Addres	s of Facilit	y N e	ewman F	uneral	Home,I	nc.
			Jul Gurs	Jeuma		9	168 M	ason	-Dix	on H	ighway,	Salisb	ury, F	PA 15558
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	aused the death each line.	. Do not ente	er the mode	of dying	g, such as	cardiac c	r respiratory ar	rest,	11	oproximate nterval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	RE	NAL	FAIL	-ur	E					i	Onset and Death
	Lxammer	-G	resulting in death)	Ν.	Due to (or	as a consequ	uence of):	1_						
	uted d ansit	Examiner		r b. Dio	3 01	as a consequ	مجلا	uTI	S					> 24rs
oʻ	ifficate be executed g physician and es the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cox	Due 10 (01	A t	D A	. 1	Nic.	00	LP.		1	> 34rs
68760,	ate be nysicii he bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>COV</u> (Due to (br	as a consequ	ence of):	1	213					1 3915
			resolving in death, East	L. Al.	zheim	n	Den	201	t	a				> lur.
Вох	eath cert attendin for use	lan/		V.										}'
P.O.	the a	Physiclan/M	Part II. Other eignificant condition	ns contributing to de	eath but not resu	Iting in the un	derlying car	use give	n in Part I.		23b. Did t	obacco use co	ntribute to t	he ceuse of death?
	requires that the death cer ben signed by the attendin hould be detached for use		Transient	Ische	mic (attac	iks	4			101	res 2X No	3 Probai	bly 4 ☐ Unknown
rds	luires n sigr uld be	d by	111.								24a. Was a	an autopsy		autopsy findings
000	ıw require s been si 2 should I	Completed	Uterine U	meen							perfor	med?		able prior to pletion of cause ath?
~	The law ate has b page 2 s	E	Huper Lipic	demia	,						1 U Y	es 2 🗷 No		res 2□ No
ita		Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	-		
×	S S iD	2	1 Yes 2 No	Hospital: 1 □ I	npatient 2 🗆 E	ER/Outpatient	3□ DOA	Othe	r: 4 ∑ Nu	rsing Hon	ne 5 Resid	ence 6 □Oth	er (Specify)	
Division of Vital Records,	ing Phy I. After thi funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending		of Injury th, Day Year)	28b. Time of Injury		c. Injury Work			8d. Describe h	ow injury occur	red	
isio	Attending or death. sctor: After by the fune	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	of Injury - At hor	mo form etro	M factors		′es 2□1		Of Location (S	tmot and Mumb	or or Dum! F	Pouto Alumbar
Ω̈́	Ital or A	Certification:	4 ☐ Homicide determi	buildi	ng, etc. (Specify))	<u> </u>	_			City or Tow			
	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edical	29a. Certifier 1 ★ Certifyin (Check only one)	Physicien: To the examiner: On the ba and man	asis of examination	rledge, death on and/or inve	occurred at estigation, in	the time n my op	e, date and inion, deat	d place, a h occurre	nd due to the o	ause(s) and ma date and place, a	nner as state and due to th	ed. e cause(s)
	Vith To t	Σ	29b. Signature and title of certifier			140			number		_ 2	29d. Date signed	d (Month, Da	y, Year)
			* Salsahei	Nounc	J) [40		2	86 S	> 5		6/13	105	
•			30. Name and address of person of A.A. A.A.	who completed caus	e of death (Item	23a) (Type, P	Print)	0100	ار. سا.	11.0	MD	21521	4	
	Sta	to.	31. Date filed (Month Day, Year)	32. B	Egistrar's Signatu	ure uc	DR, C	NOVIC	M S V	الحد	יינט.	2133	J	
	Pogietr		JUN 1 4	2005	100 .	de A	M .							

DHMH 16 Rev 6/95

			1 - For State Registrar 1. Decedent's Name (First, Middle,	State of Mary		epartmer	t of Healtl e of Dea	h and N	lental Hygi	g. No. 🤰	005	3. Time of Death
ı	Physici		Joseph	William		Harri	ls		June 2,	2005	Year	1:45 A M
	/Medio Examin		4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or Locati	ion of Death	1		y of Death	
			Lorien Life Cen	ter		Мо	ount Air	v		Car	roll	
	Funeral		,	5. Sex 7. Age (III 1 ☑ M 2 ☐ F	n yrs. last birtho	Months	1 Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day,			place (State or Foreign ntry)
	Director		218-56-5482 Usual Residence of Decedent	77	Yrs	5.			Mar. 14	,1928		York
	/land		10a. State 10b. County	10	c. City, Town o	r Location					· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	a-feh	ctor	Maryland Freder	ick	Mount	Airy						¹X Yes 2 □ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturelt, or Items 23e or 28e-f ehow eumetic event, the Medical Examinationalize multical and	Funeral Director	10e. Street and Number			10f. Zip	Code		10	g. Citizen of	What Cou	ntry?
	s 23a	rall	713 Midway Avenu				21771				SA	
	Item Item	une	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie	12. Was Decedent Eve Armed Forces?	rin U.S.	If Yes, spe	dent of Hispanic cify Cuban, Mex	: Origin? (Sp tican, Puerto	ecify Yes or No- Rican, etc.)		ce - Amen ack, White,	can Indian, etc.
930	urs af	by	3 Widowed 4 Divorced		II W	1 🗆 Yes	2 No Spec	cify:		Speci	fy: W	<i>T</i> hite
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest	Education	16a. D	ecedent's Usu	al Occupation	most of work	rina	6b. Kind of E	Business/In	ndustry
21	ithin Ber	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			rk done during r se retired)		ang .	***		
2	filed w Hygier other th		17. Father's Name (First, Middle, La	l conti	L.	THeman,	Dispato		o (First Middle 1		ities	
Maryland	d be findal Hed of	Be c	Joseph		T				e (First, Middle, N			
Ž	should ind Men marke umetic	မှ	19a. Informant's Name/Relationshi		Harris	lailing Address		mber or Aur	al Route Number,		ain . State. Zic	Code)
	is 1 and 2 should of Health and Men item 27 le marke other treumetic		Michael G. Alexa			_			rive, Mt	•		•
Baltimore,	of Health of Health fitem 27		20a. Method of Disposition		20b. Place of D		me of			Oc. Location		
E	permit. Pages Department of Important: If it eny injury or o once.		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		-		matory	6/6/2	2005 F	reder:	ick. I	MD
alt	permit. Departn Imports eny inju		21. Signature of Fune at Service Li						uffer Fu	neral	Home	, PA
<u> </u>	g ⊊ 2 9		J. toru	000					Pike, Fre		k, MD	21702
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the nly one cause on each line.	death. Do not	enter the mod	te of dying, such	as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Congestiv			re					6 Weeks
	/Medical Examiner			Due to (or as a co			_					
		e	Sequentially list conditions, if any, leading to immediate	b. Coronary Due to (or as a co			e				-	4 Years
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6								
o,	a exectan an an an an an an an an an an an an a	Exa	resulting in death) Last	Due to (or as a co	onsequence of):							
3760,	ate be executed hysician and the burial-transit	Ilcal		d.							- 1	
Ž	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE:	00-14								
Box	attenc for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 □Ectopic p 5 □ Other (st					ate of delive onth	ery Day Year
o.	at the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	e or death	3 LI Other (sp	эвспу)					
1	that ned by deta	by Ph	Part II. Other significant condition	s contributing to death but n	ot resulting in th	ne underlying o	ause given in Pa	art I.	23e. Did tob	acco use con	tribute to t	he cause of death?
rds	w requires that been signed b should be deta								1 □ Ye	s 2□No	3 🗌 Prot	oably 4 🖽 Unknown
Records,	awren s bee 2 sho	Completed							24a. Was an	24b.	Were auto	ppsy findings available
	The I	Com							autopsy perform	ed?	death?	mpletion of cause of
Ita	sien: artifica ctor, I	Be C	25. Was case referred to medical examiner?						h (Check only one			
<u> </u>	Physicien: The lav this certificate has al director, page 2	2	1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa		OA Other:	Nursing Ho	ome 5 Resider			(y)
Division of Vital	ng f fter iner	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Tim Inju	e of 2 ry M	28c. Injury at Work? 1 ☐ Yes 2	2 □ No	28d. Describe how	w injury occu	rred	
S	Vttendi death. ctor: A y the fu	icat	2 Accident Investiga 3 Suicide 6 Could no	t be	- At home farm			- 140	28f. Location (Str.	eet and Num	ber or Aura	al Route Number
2	after after Direct	ertii	4 ☐ Homicide determin	building, etc. (5	Specify)	, 51.001, 12.0101	y, omoo		City or Town,			
	spite hours nerel y fillec		29a. Certifier 1 Certifying	Physician: To the best of m	ıy knowledge, d	eath occurred	at the time, date	and place,	and due to the ca	use(s) and m	anner as s	tated.
	he Ho n 24 l he Fu pletel	Medical	(Check only 2 Medical B: one)	caminer: On the basis of ex- and manner stated	amination and/c l.	or investigation	, in my opinion,	death occur	red at the time, da	te and place,	and due to	o the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	1, ()		29	c. License numb		29	d. Date sign		
١.,	X		*	MI			D-319	912		June	4, 20	005
ŧ.	7		30. Name and address of person w									
			Dr. Julio Menoc	32 Magistrar's	Opossum Signatur	town P	ike, Fre	ederic	k, MD 21	702		
	Sta Registr		JUN 0 7	2005	V A	Aparti	7					

Funeral

Director

item 27 le marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, It e Medical Examinar must be notified at

Maryland

the

72 hours after

d 2 should be filed within 72 th and Mental Hygiene. 7 Ie marked other than "nu

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a,27,28a-f per me 6844.6-21-05 tas
Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Justie 7, 2005 **Physician** Year 1930P. Habteslasie Tecleab /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2105 Charleston Place Prince Georges Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-21-1980 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □XM 2 □ F Days Hours Min Months Yrs 578-33-2472 24 Eritrea Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Maryland P.G. Hyattsville TX☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 2105 Charleston Place Eritrea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 🏋 No Specify: Specify: Black Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Gas Station Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Mengestu Habteselassie Tabotu Woldeyohannes 19b. Mailing Address (*Street and Number or Ryral Route Number, City or Town, State, Zip Code*) 1221 M Street, N.W. #224 Washington, D.C. 20005 19a. Informant's Name/Relationship (Type, Print) Menpestu Habteselassie/father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-17-05 Asmara, Eritrea Family Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. Wanda 3447 14th St., N.W. Wash., D.C. 20010 7,00361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical **Examiner**

physician and the burial-transit

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detached

Box 68760

P.0.

Records.

Division of Vital

Hospital or At ending

death

Director:

24 hours

within 2 To the

Examine

Physician/Medical

þ

Completed

2

Certification:

permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trau

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

mmediate Cause (Final

disease or condition resulting in death)

Contact Gunshot Wound To The Head Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1X Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3X Suicide

4 | Homicide

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4 Pregnant at time of death 9 Unknown

3 □Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Dav

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2 No 2□ No TE Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 28d. Describe how injury occurred

scene

28a. Date of Injury **Found** Day Year) 28b. Time of Found 7:20 6-7-05

1 🔲 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Subject Shot Self 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2105 Charleston P1

Scene 29a Certifier

5 Pending investigation

6 Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

<u>Hyattsville, Md</u>

24a. Was an

29b. Signature and title of certifier

29c. License number OCME

29d. Date signed (Month, Day, Year) June 8, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland 21201 RUBIO, ANA

31. Date filed (Month, Day, Year) JUN 1 4 2005

MD

2. Registrar's Signature

State Registrar

			Please 1 - State Registrar		it in Black In	artment of I	Health and N		_	
			Registrar 1. Decedent's Name (First, Middle, La:	and .	Ce	rtificate of	Death	Reg	3. No.	12015
(c)Rec	Physici /Medio		William Hardy					April	29 2005	3 Time of Death
	Examir	ner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Death		4c. County of Death	1
	Funeral Director		5/9-32-6549	ospital ex 7. Age MM 2□F	e (In yrs. last birthday) 94 Yrs.	Sillif Under 1 Year Months Days		ng 8. Date of Birth (Month, Day, Y April II	9 Birth	gomery nplace (State or Foreign thirty Virginia
	aryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	he Ma 28a-1	Director		George's		Lanha	am		000	1 Yes 2 No
	with t		10e. Street and Number 9109 - 8th	St.		10f. Zip Code	20706	100	g. Citizen of What Co United	
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent 8	ever in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,
21215-0036	be filed within 72 hours atter death with the Maryland ital Hygiene. d other than "neturel", or Items 23a or 28a-f show event, the Mcdical Examinational be notified at	b	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	1 Tes, specify Cub 1 ☐ Yes 2 🔀 No	san, Mexican, Puerto Specify:	rican, etc.)	Black, White AT Specify: Am	rican erican
ر ک	72 h	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occu	during most of work	sing 16	6b. Kind of Business/l	ndustry
7	within ene. then he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) //re.	DO NOT use retire Fede:	cal Employ	zee	Govern	ment
D	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)			- reac.		e (First, Middle, Ma		
<u>la</u>	should be filed and Mental Hygi marked other umatic event,	To B	William Hard	ły				Melinda	a Oliver	
Maryland	0 8 8	l a	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	and Number or Rur	al Route Number, (City or Town, State, Z	ip Code)
	1 and 2 Health tem 27	1.	Sandra Pierce 20a. Method of Disposition	- Daughte:	20b. Place of Dispo	707 Woods	row St., I		ille, SC Oc. Location - City or 1	29512
Baltimore,	ages nt of th t; if ite		1 Burial 2 □ Cremation 3 □	ice)	/2005	Washingt				
	permit. Pages Depirtment of I Importent; if ite any injury or of once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service,Licer	A. A		vet Cemet 2. Name and Addre			uneral Hom	
ñ	Per Dep any successions	Į.,	I low T.	Steroait	11()	4001 Be	enning Rd	, N.E. W	ash., DC 2	0019
	Pnysician	65)	23a. Part1 Inter the disease, or com shoc, o heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	whe death. Do not enter.			or respiratory arres	t,	Approximate Interval Between Onset and Death days
	/Medical Examiner		resulting in feath)		a consequence of):					
		Į.	Sequentially list conditions, if any, leading to immediate gatter. Each Underlying	b. Ref	nal insuff	iciency				years
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	0220	15774 1767					vears
60,	be executed sician and burial-transit		resulting in death) Last		consequence of):					years
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g Xog	death certificate e attending physi d for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at	2 Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of delin	very Day Year
J O		hys	9 Unknown	9□ Unknown						
cords, I	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	contributing to death be	ut not resulting in the u	nderlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
ğ	sicien: The law re certilicate has be irector, page 2 sho	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
VII	cien: ertifica actor,	Be C	25. Was case referred to medical examiner?					h (Check only one)		
Ö	ing Phy ifter this ineral d	tlon; To	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	and the second s	f 28c. Inju Wo	ner: 4 □ Nursing Ho ry at rk?] Yes 2 □ No	ome 5 Residence 28d. Describe how	ce 6 Other (Spec	ify)
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, sti c. (Specify)	reet, factory, office		28f. Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
	ne Hospit n 24 hour ne Funere	Medical C	(Check only 2 Medical Exam	nysician: To the best on niner: On the basis of and manner sta	examination and/or in	h occurred at the t vestigation, in my	me, date and place, opinion, death occur	and due to the causered at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the within To the comp	Me	296. Significance and title of certifier			29c. Licen			I. Date signed (Month	. Day, Year)
)			2 A Namy	ar w	0	DST	0987		41301	05
6	RD		30. Name and address of person who A I + MED - VAW	AZ POB	0X 8381	Print) GG	0987 wither	Sbur	mp 2	0883
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 7 200	5 Registra	r's Signature	de			,	

			1 - For State Registrar			laryland		rtment of F			R	eg. No.	105	20417
ı	Physici /Medic		1. Decedent's Name (First, I	Middle, Lasi	Nich	olas		Irish	1	2	June 3	, ^{Day} 00	5 Year	3. Time of Death 2:45 aM
1 2	Examin		4a. Facility Name (If not inst 18056 Rolli	ng Me	adow Way		and high days	4b. City, Town, o Onley			Data of Birth	Mont	gomery	
1001	Funeral Director		5. Social Security Number 299-30-6786 Usual Residence of Decede		XM 2□F 7.A	68	ast birthday) Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day NOV . 6,	1936	Oh	olace (State or Foreign ntry) 10
	Maryland -f show	tor	10a. State 10b. Co		ry		, Town or Lo Ley	cation						10d. Inside City Limits X☐ Yes 2 ☐ No
	with the 3c or 28a	l Direc	10e. Street and Number 18056 Rolli	ng Me	adow Wav			10f. Zip Code 20832)		1	_	of What Cou	ntry?
336	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I then the marked other than "natural", or Items 23c or 28a-1 show other traumatic event. Its Medical Evant are must be inclified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 X Divi	Married	12. Was Deceden Armed Forces 1 Tyes 2 2 If Yes, Give Year or Dates	? No		Vas Decedent of H f Yes, specify Cuba		gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)	14.	Race - Ameri Black, White, ecity: Whi	etc.
21215-0036	within 72 ho iene. r than "natura the Medical I	ompieted	15. Dec (Specify only I Elementary/Secondary (0		cation de completed) College (1-40r 5+	5+)	(Give life. I	lent's Usual Occup kind of work done DO NOT use retired	ation during most d)	t of working	7		of Business/In ral Re	_{dustry} serve Board
	12 should be filed within in and Mental Hygiene. 7 Is marked other than "fraumatic event, the Men	To Be C	17. Father's Name (First, Mi								First, Middle,			
Maryland	nd 2 shou lith and M 27 Is mar r traumat	-	19a. Informant's Name/Rela Leslie Case		_{урв, Print)} (Daughte:	r)		g Address (Street 54 Angelt						. 20866
Baltimore,	8 ° = 5		20a. Method of Disposition 1 □ Burial 2 □ 1 □ Perma 4 □ Donation 5 □ Oth			_ Ce	emetery, crer	sition (Name of natory or other place ke Cremat	cory C	Dai -04-			on - City or To ${ m ville}$,	
Balti	permit. Pa Departmen Important: any injury once.		21. Signature Funeral Se	1	Bacen C	2C 30		. Name and Addre		W.	H. Bac	on Fur hingto	neral l	Home, Inc.
	Physician /Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or comp List only o	lications that cause one cause on each	nal	car	er the mode of dyir		cardiac or	respiratory arr	est,	-01	Approximate Interval Between Onset and Death
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ds, P.	juires that the signed by ald be detacted	by	Part II. Other significant co	nditions co	ontributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	-		he cause of death?
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ion of	ding Ph J. After th funeral	ation: T	27. Manner of Death 1X Natural 5 ☐ F	ending vestigation	28a. Date of In (Month, D	jury	28b. Time of Injury	28c. Injur Wor		28	d. Describe h			,,
Division	tal or Atte s after des al Directo ed in by th	Certification:	3 Suicide 6 C 4 Homicide	ould not be etermined	200. Flace 011	njury - At ho etc. <i>(Specif</i> y		eet, factory, office		28	f. Location (S. City or Tow	treet and No n, State)	umber or Rura	al Route Number,
	To the Hospital or Attenswithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai			ysician: To the bes liner: On the basis and manner:	of examinal								
	To the within 2 To the complete	×	29b. Signature and title of o	ertifier 1	Len 6	Umn		29c. Licens D359					gned (<i>Month,</i> 2005	* * * * * * * * * * * * * * * * * * * *
R			30. Wime and address of p. Linda M.	Burre					lvd S	Suite	#400	Wheat	on, Md	. 20902
	Sta Regist		31. Date filed (Month, Day, JUN 0	^{Year)} 2005	2. Regis	strar's Signa	Sons.	1						

			For State	Plea	• -			nd / Depa	artment of	Health and	-		•	ie.	
			1 - State Registrar	- (F) - 1 A S 1 H				Cei	rtificate of	Death		Reg. No	ZU0	£.,	20418
I	Physici /Medic	al	1. Decedent's Name	AN	М			KSON			2. Date of Month JUNE	Da			5:27 A. M
	Examin	er	VA HOSPI		i, give stree	it and numbe	r)		BALTIMO	or Location of De RF.	eath	40	. County of	Death	
	Funeral		5. Social Security N		6. Sex		Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 h		Birth	9). Birth:	place (State or Foreign
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	anylan show d at	_	10a. State	10b. County			10c. Cit	ty, Town or Lo							10d. Inside City Limits 1. Yes 2 ☐ No
	he Ma	Director	VA 10e. Street and Nur		deric	k		Win	chester	<u> </u>		10- 0	**4 14 <i>t</i> b	-10-	
	with I			Rossur	n Lar	ne.			10f. Zip Code	502		lug. C	tizen of Wh		ntry?
٥	hours after death with the Maryland turel', or litems 23s or 28e-1 show al Everifret must be rollified at	Funeral	11. Marital Status		12. V	Was Deceder Armed Forces XYes 2 (f Yes, Give	s?	7-	Was Decedent of If Yes, specify Cub	Hispanic Origin? pan, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Black, Specify:	Americ White,	
2	72 hours 'naturel', dical Exe	d by	3 🗆 Widowed		`	ear or Dates	196	7							
215-0036	72	Completed		15. Decedent	st grade co	mpleted)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. F	and of Busin	ness/In	dustry
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<u>ရ</u>	1 ar Hea em		20a. Method of Disp						Rossum esition (Name of matory or other pla		Date		ocation - Ci		
saitimore,			1 🖾 🗞 rial 2 (`4 🗆 Dogation			val from Stat		avel &	Charity	y Ce 6,					
<u>a</u>	permit. Page Department Importent: If any injury or once.		21. Signature of Fu	neral Service	Licen Lee	D	1	22	2. Name and Addr	ess of Facility	nowden	Fur	eral	Ho	me, P.A.
<u>n</u>	89 = 29		Xte	uge	X	free	in	7					KV11	те,	MD20850
			23a. Part1. Enter the shock, or hea	,	complication	ons that caus	ed the deat line.	/ 1	er the mode of dy	1		arrest,			Approximate Interval Between Onset and Death
- 1	Physician /Medical		Immediate Cause (disease or conditio resulting in death)	n n	_ a	cerel	06/16	er h	emorr	hage	/				
	Examiner					Due to (or a	is a conseq	quence of):	Com)					
L.		ner	if any, leading to in cause. Enter Unde Cause (Disease or	nditions, imediate adving	Ь. —	Due to 1	is a conseq	quence of):						1	
	be executed ician and burial-transi	Examiner	Cause (Disease or that initiated events resulting in death) I	•	c	Due to /or o									
ر ور	be exician a	cai E)	, , , , , , , , , , , , , , , , , , ,		Į.	Due to (or a	is a conseq	(uence or):							
200	ficate p phys				d										
. Box	it the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2	months? ⊒No		f yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of d	aldeath 3□	Ectopic pregnanc Other (specify)	ey .		-	23d. Date o Month		ery Day Year
r Ö	hat the	Phy	9 Unknown Part II. Other signif		ans contribu	iting to death	but not res	sulting in the u	nderlying cause o	ven in Part I	23e Die	1 tobacco	use contribu	ite to th	ne cause of death?
ďs,	iw requires that the s been signed by th s should be detache	d by	, and an angular			g to coun.	5011101100	and an area	ndonying daddo gi	TOTAL CALL.					ably 4 Dunknown
Cord	> 0 0	ompieted									24a. Wt		24b. We	re auto	psy findings available
Ĭ.	9 4 9	mo								· - · - · - · - · - · - · - · · - ·	pe	topsy rformed? 2 \(\square\) No	dea	ţh?	mpletion of cause of 2□ No
VItal	icien: Th certificate ector, pag	Be C	25. Was case reference examiner?	red to medical						26. Place of E	Death (Check only		,,,,	. 00	
010	ys dir	2	1xxxYes 2□		Hosp	1 LAInpa		ER/Outpatien	IL SEL DOA		g Home 5 ☐ Re			(Specif	y)
	ling After une	ation;	27. Manner of Death 1 Natural 2 Accident	n 5 ☐ Pendin- investig	g	Ba. Date of In (Month, E	jury Day Year)	28b. Time of Injury	Wo	iryat ork?]Yes 2 ☐ No	28d. Describ	e how inju	ry occurred		
DIVISION	F 5 F C	Certificati	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could r determ		Be. Place of li building,	njury - At he etc. (Specif	ome, farm, str	eet, factory, office			(Street arown, State		or Rura	I Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edicai C	29a. Certifier (Check only one)		Examiner:		of examina		occurred at the t vestigation, in my						
	To the within To the	Me	29b. Signature and	title of certifier		/	10		29c. Licen	se number		29d. Da	te signed (A	Month,	Day, Year)
			> A	VI	Ar	\forall V	V		OCM	E		JUNE	3, 20	005	
	6		30. Name and address	ess of person	who comple	eted cause of	death (Iten	п 23а) (Туре,	Print) 111 Pa	nn Stree	et Balti	imore	Mary	v1 ar	nd 21201
	Sta		31. Date filed (Mont	th. Dav. Year)	571	32. G qis	strar's Signa	atuse.	/ / .	- Durce		THOT C	, rul	,I	.v. 41401

Registrar

JUN 0 6 2005 Seren 15

State Registrar Pamer E. Southou, Mis
31 Date filed (Month, Day, Year)

JUN 1 3 2005

22. Registrar's Signature

30. Name and a Hoss of

rson who completed cause of death (Item 23a) (Type, Print)
111 Penn Street Baltimore, Maryland 21201

6

June

2005

		1 - State Registrar	State of Marylan	_	rtificate c			Reg. No.	15 2048
Physici	ian	Decedent's Name (First, Middle, La.					2. Date of D Month		3. Time of Deat
/Medi Examir		Robert 4a. Facility Name (If not institution, give		Jackson	1	, or Location of De	June ath	1 20 4c. County of	05 8:15 P
	Ш	Mariner Nur				ilver Spr	ing	Мо	ntgomery
uneral		5. Social Security Number 6. S	TXM 2 TF	Ven	If Under 1 Ye Months Day		n. (Month, L	Sirth Day, Year)	Birthplace (State or Form Country)
irector		577-14-3275 Usual Residence of Decedent	81	6 113.			Sept.	2, 1918	Virginia
Show		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Lin
a-f s	Funeral Director	DC				Washin	øton		1 ∑ Yes 2 □
or 28	Oire	10e. Street and Number			10f. Zip Code	9	D.	10g. Citizen of Wh	at Country?
23a	rai		ood Dr., SE			20020			ed States
Items Defin	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? uban, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	lo- 14. Race - Black,	American Indian, White, etc.
od other then 'naturel', or leams 23a or 28a-f shov event, the Medical Examiner must be incliffed at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates;		1□Yes 21XIN	lo Specify:		Specify:	B1ack
ature ical E	ted	15. Decedent's Ed	ducation	16a. Deced	dent's Usual Occ	cupation		16b. Kind of Busi	ness/Industry
Med "n	ple	(Specify only highest gra	College (1-4or 5+)	(Give life. I	kind of work doi DO NOT use ret	ne during most of w ired)	rorking		
1 th 1	Completed		2		Aircraf	t Mechan	ic	USAF(DO	D) Governmen
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	e, Maiden Surname)	
marked other then	၉	Phillip Jacks						e Clory	
<u>s</u> = 10	1	19a. Informant's Name/Relationship (ber, City or Town, St.	ate, Zip Code)
item 27 other tr		20a. Method of Disposition				ood Dr.,	Wasn., D	C 20020 20c. Location - Ci	hu or Tourn State
= =		1 ☑ Burial 2 ☐ Cremation 3 ☐	i idilioval flotti State		sition (Name of natory or other p				
Important: any njury c		 4 ☐ Donation 5 ☐ Other (Specify 21. Signature, 1 Fun-ral Service Licenters 			oln Ceme		6/2005	Brento	
any		21. digital di Vice Elder	Stanga VI	77 1"				Funeral Ho Wash., Do	
		23a. Part1. Enter the disease, or com	plications that caused the death	n. Do not ente					Approximate
sician		SHOCK, Of Heart failure. List only	one cause on each line.						Interval Between Onset and Death
ledical		Immediate ausé (Final disease or adition resulting in dami)	a. Sepsis Due to (or as a consequ	rence of).					Days
aminer			Pneumonia						Days
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						1,7
physician and the burial-transit	Ü	resulting in death) cast	Due to (or as a consequ	uence of):					100
y al	edical	•	d						
attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ncv				22d Data	f dollars
atter d for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnar Other (specify)			23d. Date of Month	
detached	hysi	9 Unknown	9□ Unknown						
s been signed to should be deta	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	nderlying cause	given in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
en sig		End Stage	Renal Disease				1 🗆	Yes 2□No 3[☐ Probably 4 Munkno
W C/1	Completed	Diabetes	Mellitus				24a. Was		re autopsy findings availa
ate pag	mo:							ormed? dea	r to completion of cause th? Yes 2 \sum No
is certificate director, paç	Be C	25. Was case referred to medical examiner?				26. Place of De	eath Check on	×	
S in	2	1 ☐ Yes 2 🐴 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	t 3□ DOA C	other: 4 Nursing	Home 5□Res	idence 6 🗆 Other ((Specify)
Viter t unera	on:	27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W	ury at 'ork?		how injury occurred	
tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be			-	□Yes 2□No			
Direc in by	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, offic	8	28f. Location (City or To	(Street and Number o wn, State)	or Rural Route Number,
To the Funerel Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, death	occurred at the	time, date and place	e, and due to the	cause(s) and manne	er as stated.
the F	Medical	29b. Signature and title of certifier	iner: On the basis of examinat and manner stated.	ion and/or inv		nse number	curred at the time,	date and place, and 29d. Date signed (A	
0 5									, Day, I call
То									
200		30 Name and address of person who o	completed cause of death (Item	22a) /F: 1		32332		June 3	, 2005

Richard Koch 05-04026 MLO

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene
1- State of Death Reg. No. 2 0 5

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "naturel; or items 23a or 28e-1 show any injury or other freumetic event, the Marical Example transfer any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event, the Marical Example to any injury or other freumetic event in any injury or other freumetic event in any injury or other freumetic event in any injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic event injury or other freumetic

Fnysician
/Medical
Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

	202 A Harlay DEL	v —			westmins	ster		Uč	arroll		
	5. Social Security Number 224-84-4940	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 46	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	C	thplace (State or Foreign ountry)	
			40		L		12/24	./19.	<u>58_VII</u>	RGINIA	
	Usual Residence of Decedent		T								
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
ctor	MD CARRO)LL	V	VESTM)	INSTER					1 □ Yes 2 🎇 No	
)Irec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What C	ountry?	
al	202 A MANDY D	R.			211	57		U:	SA		
ne	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No	- 1	14. Race - Am	erican Indian,	
Ē	1 ☐ Never Married 2X Marrie	Armed Fe ed 1 ☐ Yes	2 X 1No			an, Mexican, Puei	to Rican, etc.)		Black, Whi	te, etc.	
d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or D	Ve		1□Yes 2█No	Specify:			Specify: Wh	HITE	
lete	15. Decedent's (Specify only highest	s Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	orking	16b. Kir	nd of Business	/Industry	
Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	INSTAI		SEC	URITY		
O	17. Father's Name (First, Middle, L.	ast)		1		18. Mother's Na	me (First, Middle,	Maiden !	Sumame)		
To B	KENNI	ETH	K	OCH			BERTA		McCR	ACKAN	
	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	er, City or	Town, State,	Zip Code)	
	VICTORIA E. K	OCH -	WIFE		A MANDY	DR., W	ESTMIN:	STER	, MD.	21157	
	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	(a)	Date	20c. Loc	cation - City or	Town, State	
	XBurial 2 □ Cremation 3	3 ∐Removal from ecify)	State LAKE	VÍEW	MEM. PA	RK 6/1	6/05	ELDI	ERSBUF	RG, MD.	
Ì	21. Schal Par Lineral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL 254 E. MAIN ST., WESTMINSTER, M										
1											
	23a. Perti. Enter the disease, or c shock, or heart ailure. List o Immediate Cause (Final	nly one cause on	each line.					rest,		Approximate Interval Between Onset and Death	
	disease or condition resulting in death)	_ a Athe	roscler	otic ca	ardiovasc	ular dis	sease				
	rosulting in docum	Due to	(or as a consequ	uence of):							
	Sequentially list conditions,	b									
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	Jence of):							
am	Cause (Disease or injury that initiated events resulting in death) Last	c									
۱۳	1650ttillig ill death) Last	Due to	(or as a consequ	Jence of):							
Ca	,	d									
Med	IF FEMALE:										
2	23b. Was decedent pregnant	23c. If yes, ou	come of pregna)			23	3d. Date of del	livery	
C	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□ Pregr	ant at time of de		lEctopic pregnancy Other <i>(specify)</i>				Month	Day Year	
hys	9 Unknown	9□ Unkn	own								
by Physiclan/Medical Examiner	Part II. Other significant condition	s contributing to d	eath but not resu	ılting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?	
ted b							1 □ Y	′es 2 🗆	No 3□Pr	obably 4 Unknown	
							24a. Was	20	24h Wors	utopsy findings available	
autopsy prior to cor										completion of cause of	
000								2 □ No	death?	2 🗆 No	
E E	25. Was case referred to medical examiner?	Hospital:			0.4		ath (Check only o	ne)			
2	1½ Yes 2□ No			ER/Outpatien		4 Nursing r	fome 5 Resid			cify)	
0	27. Manner of Death 1	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury	occurred		
at	2 ☐ Accident investiga					Yes 2 □ No					
ti ti	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	280. Place	of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and	Number or Ru	ıral Route Number,	
Ce		Julia	J (- poonly	,			3.1, 01 1 ON	., Jiaio/			
Medical Certification:	29a. Certifier 1 Certifying (Check only one)	Physician: To the caminer: On the b and man	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occu	e, and due to the corred at the time, o	ause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
₹	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Monti	h. Dav. Year)	
		, -1			•				,		
	7 hude	el. K	· y n	-2	00	ME		Jun	e 13, 2	2005	
	30. Name and address of person wi	no completed caus	e of eath (Item	2 a) (Type, I	Print)						

Registrar

HEODORE MIK

31. Date filed (Month, Day, Year)

32 Registrar's Signature

111 Penn Street Baltimore, Maryland 21201

			1 - For State Registrar	State of M	aryland /		artmen rtificate					ene g. No. 🤈 🎧		00	100
I	Physic /Medi		Decedent's Name (First, Middle, Last	Olive Bra	adley Kell	у		-			2. Date of Death Month	Day	Year	3. Time (2
	Examir		4a. Facility Name (If not institution, give $SREDHEA$ 5. Social Security Number 6. Se	Rt Hosi	e (In yrs. last t	hirthday	4b. City,	mE	Location of ER	441	2 0 8. Date of Birth	4c. Count	y of Death	ANI	/
	Funeral Director		215-20-6494 1	M 200 F	97	Yrs.	Months	Days	Hours	Min.	(Month, Day, September			place (State ntry) Marylar	
	Maryland -f show	tor	10a. State 10b. County	gany	10c. City, To	wn or Lo	cation]	Lonaco	ning				10d. Inside (City Limits
	h with the	Funeral Director	10e. Street and Number 57 Jack	son Street	J		10f. Zip	Code	2153	9	10	g. Citizen of	What Cou US		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumetic event, its Medical Exactifics must be rediffed at ances.	Þ.	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 If Yes, Give Year or Dates:			Was Deced f Yes, spec	1 4	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. White	
Maryland 21215-0036	I within 72 ho iene. r then "natur the Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5		a. Deced (Give life. I	lent's Usua kind of wor DO NOT us	k done d e retired)	tion buring most rses Ai		ng 1	6b. Kind of B	Jusiness/In	,	
land ?	ild be filec ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last)	incoln Bradle	ey .				18. Mothe	r's Name	(First, Middle, M Margar	aiden Sumai et McKe	ne) enzie		
_	and 2 should ealth and Men n 27 is marke ser treumetic		19a. Informant's Name/Relationship (Ty Paul Kelly -	pe, Print) Son	19	9b. Mailin					Route Number, Keyser, We				
altimore,	Pages 1 and nent of Heisont: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 F Donation 5 Other (Specify)	emoval from State		ery, cren	sition (Nam natory or ot Catholi	her place		D	ate une 14, 2005	0c. Location Lona		own, State Maryland	d
Balt	permit. Departr Importe any inji		21. Signature of Fune a Service Licens	SKing	M		Name and				ome 8 East N	⁄ain St., I	onacon	ing, Md.	21539
8760,	Physician and physician and physician street is the purish-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	10.	e of): Przt e of):					r respiratory arres - Faulu v		i	Approxima Interval Be Onset and	tween
O. Box 68	ath certif titending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pre Other (spe			-			te of delive		Year
rds, P.	quires that the de n signed by the a uld be detached f		Part II. Other significant conditions cor	tributing to death bu	ut not resulting	in the un	derlying ca	use givei	n in Part I.		23e. Did toba	./		ne cause of c	
al Records,		Completed						-			24a. Was an autopsy performe 1 Yes 2	ed?/	prior to cor death?	psy findings npletion of a	
Division of Vital	To the Hospitel or Attending Physician: which 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification; To Be	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Unpatie 28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	28 M	C. Injury Work	4 Nur	rsing Hom 2!	Check onl one) de 5 ☐ Residen 8d. Describe how 8f. Location (Stre	injury occur	red		
2	ipitel or A burs after lerel Dire filled in by		4 Homicide determined 29a. Certifier 1 Certifying Physical Events and Chapter 1 Medical Events and Cha	28e. Place of Injubulding, etc						1	City or Town,	State)			iber,
	To the Hos within 24 h To ths Fur completely	Medical	(Check only one) 2 Medical Examir one)	er: On the basis of and manner sta	examination at	nd/or inv	estigation,	n my opi	nion, deat	h occurred	d at the time, date	and place, Date signer	and due to	the cause(s	3)
	<i>i</i>		> S' Cha	nem	D				563		9	eme	11	200	5
	(P Sta		30. Name and address of person who co SATURIVINA TON 31. Date filed (Month, Day, Year)	ANG M.D	i 070/ in's Signature	Nec	V Hed	70.2 C	Preels	Fro	Along	MAR	ylar	421	532
	Registr		JUN 14 2			* 4	South.	<i>B</i>							

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland		artment of rtificate of				eg. No.	UUS	2 1 2 3
7	Physici /Medic Examir	cal		ret C. Kipke		4b. City, Town,			Month June	6 4c. Co	Year 2005 unty of Death	12:00 A ^M
	Funeral Director		5. Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Yea Months Days	r If Under 2	Min.	8. Date of Birth (Month, Day, Dec 14,	Yeer)	9. Birth Cou	place (State or Foreign ntry) orida
	death with the Maryland ms 23e or 28e-f show	Director	10a. State 10b. County MD Howard 10e. Street and Number		Town or Lo				1	Og Citizer	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
036	within 72 hours after death with the Maryland ene. Than "natural", or flems 23e or 28e-f show the Marcical Examiner mant be mailfied at	by Funeral	6336 Cedar Lane #3	44 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	'		044 Hispanic Orig ban, Mexican,	gin? (Spec , Puerto P	ifv Yes or No-	U1	nited & Race - Ameri Black, White, ecity: Whi	States can Indian, etc.
21215-0036	be filed within 72 hours after dea tal Hygiene. d other than "netural", or items event, the Matacal Examine to	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work done DO NOT use retir	e during most red)	of workin	g		of Business/Ir	dustry
2		To Be C	17. Father's Name (First, Middle, Last) David Harmening		10. 11.		18. Mother	Cora		Maiden Su	mame)	
Σ	1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship (Type Kenneth Kipke/Son 20a. Method of Disposition	20b. Pla	7680	ng Address (Stree Bush Ave sition (Name of	enue Pa		na, MD	21122		
<u>a</u>	nt. Page entment o ortant: If injury or		1 ☐ Surial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Cro	wnsvi	natory or other pl 11e Vet. . Name and Add	. Cem.				sville s Fami	e, MD ly FH Inc.
0	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death.	4	112 Old	Columb	oia P	ike Ell	icott		MD 21043 Approximate Interval Between Onset and Death
	Medical Examiner	lical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause jusease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):							6 + years
O. DOX O	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal o 4□Pregnant at time of dea 9□Unknown	leath 3 🗆	Ectopic pregnand Other (specify)	су			23d.	Date of deliver	ery Day Year
ecolds, P.	w requires that is been signed by should be deta	by	Part II. Other significant conditions conf	tributing to death but not result	ting in the ur	nderlying cause g	iven in Part I.			acco use o		ne cause of death?
		Completed							24a. Was ar autopsy perform 1 Yes 2	red?		psy findings available mpletion of cause of 21 No
Division of Vital	or Attending Physics death. Irector: After this iby the funeral dis	Certification: To Be	25. Was case referred to medical examiner? 1 Yes	ospital: 1 Inpatient 2 El 28a. Date of Injury (Month, Day Yeer) 28b. Place of Injury · At hombuilding, etc. (Specify)	8b. Time of Injury	28c. Inju Wo M 1	ther: 4 Nursury at ork? Yes 2 N	sing Home 28	Check only one 5 Reside d. Describe ho If. Location (Str. City or Town,	nce 6 winjury or	curred	y) J Route Number,
	To the Hospital or within 24 hours aft To the Funeral Di completely filled in	edical Ce	29a. Certifier (Check only one) 1 Cartifying Phys 2 Medical Examin	ician: To the best of my knowl er: On the basis of examinatio and manner stated.	ledge, death on and/or inv	occurred at the trestigation, in my	time, date and opinion, death	l place, an	d due to the ca	use(s) and ite and pla	manner as si ce, and due to	tated. the cause(s)
	To t To ti comp	M	29b. Signature and title of certifier P. Pates			D3	71))			June	7, 20	05
) a	Ĵ Sta	te ar	30. Name and address of person who core 606 H Am m 31. Date filed (Month, Day, Year)	and the second s	V6	BALT	mon	ME	MD	212.	25 PR	AFULL G. PATEL, M.O.

Please Type or Print in Black Indelible Ink. Ens	sure All Copies Are Legible.
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			1- State of Maryland	-	artment of rtificate of				giene Nos. No.	005	20424
	Physici	an	Decedent's Name (First, Middle, Last)				2.	Date of Dea Month	ith Day	Year	3. Time of Death
A I	/Medic		WESLEY SAMUEL KIDWELL					ine2,20			6:55pm M
4	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town,		of Death			unty of Deat	th
			Civista Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last	birth day)	LaPlat		24 Hrs o	Data of Dist	Char		
	Funeral Director		217–30–0901	Yrs.	Months Days		Min.	Date of Birth (Month, Day	r, Year)		thplace (State or Foreign
			Usual Residence of Decedent				Fe	eb 13	1934	Mai	cyland
	yland		10a. State 10b. County 10c. City, T		cation						10d. Inside City Limits
	Mar-1 st	tor	Maryland Charles Wald	orf							1 X Yes 2 □ No
	th the	Directo	10e. Street and Number		10f. Zip Code			1	10g. Citizen	of What Co	puntry?
	th wil	aic	11518 Terrace Drive		206	02				USA	
	and and and and and and and and and and	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of f Yes, specify Cu	Hispanic Ori	gin? (Specif	y Yes or No-	14.	Race - Ame Black, Whit	encan Indian,
98	or it	Y.	1 Never Married 2 Married 1 Yes 2 No	1	1 ☐ Yes 2 ☐ TNo					e <i>city:</i> Wh	
5-0036	72 hours after death with the Maryland Inatural; or Itams 23a or 28a-f show dical Examinat must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:								
7	"nat	Completed	(Specify only highest grade completed)	(Give	dent's Usual Occu kind of work don DO NOT use retir	upation e <i>during mos</i> red)	t of working		16b. Kind o	of Business/	Industry
12	within ene. than "	mc	Elementary/Secondary (0·12) College (1·4or 5+)		ouse Pai				Co	nstru	ction
9	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		Jude 141		er's Name (F	irst, Middle,			
Maryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	To Be	Sanuel W. Kidwell			Inez	z E. K	idwell			
ary	shound M	-	19a. Informant's Name/Relationship (Type, Print)	oute Number	r, City or To	wn, State, 2	Zip Code)				
	1 and 2 Health a iem 27 is		Donna J. Sturgill (Cousin)	Way W	White :	Pls.,	Mary1	and 20	0695		
ē,	of Health of Health filem 27 i		20a. Method of Disposition 20b. Place	sition (Name of natory or other pl	ace)	Date		20c. Locati	on - City or	Town, State	
E	Pages nent of I int: if its iry or o			Cemetery		5-6-05		Waldo:	rf, M	D	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signafre of uneral Service Licensee M00173	Eber	wein F White	unera Pls.,	1 Ser MD 20	vices 0695			
			23a. Part1. Enter the disease, or complications that caused the death. I		Approximate						
	Physician		shock, or heart failure. List only one cause on each line.		1.115	-0					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a		ANCE	1				-	PEN IR
	Examiner		Sequentially list conditions b.								
	D ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):							
	acute ind trans	Examiner	that initiated events c.								
30,	cate be executed obysician and the burial-transit	ũ	Due to (or as a consequen	ce of):							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d								
9 x	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	,						5	
Вох	attendation for us	ian	in the past 12 months?	ath 3□	Ectopic pregnan Other (specify)	су			23d.	Date of deli Month	ivery Day Year
o.	at the de by the a tached	ysic	1 Yes 2 No 9 Unknown	. 3	Cities (specify)						
<u>α</u>	res that th igned by be detac		Part II. Other significant conditions contributing to death but not resulting	ig in the ur	nderlying cause g	iven in Part I.		23e. Did tol	bacco use o	contribute to	the cause of death?
Vital Records,	uires n sign	d by	PROSTATE CANCER					1 🗆 Y	es 2 🗆 N	o 3 🗆 Pr	obabiy 4 Hinknown
00	w requir been si should	Completed	DIABETES MEllitu	C				24a. Was a	ın 24	tb. Were au	itopsy findings available
Re	The lay ate has page 2	шс	RENAL PAILURE	******				autops	med?	prior to death?	completion of cause of
tal		a)	25. Was case referred to medical			26 Place	of Death (C	1 ☐ Yes :	21/2 No	1 🗌 Yes	2□ No
>	9 10 7	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3 DOA	ther: 4 🗆 Nu				Other (Spec	Cify)
of			27. Manner of Death 28a. Date of Injury 28	b. Time of		ury at		. Describe ho			say)
ion	Attending r death. ector: After 5y the fune	atio	1 SNatural 5 Pending (Month, Day Year) 2 Accident investigation	Injury		ork? ⊒Yes 2⊡I	No				
Division	or Attence after death Director: in by the	iffe	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	9	28f.	Location (SI City or Town		umber or Ru	ural Route Number,
Ö	tal or A	Certification:	Building, Ste. (Gpacify)						n. Diato,		
	To the Hospital or within 24 hours afte To the Funeral Directional Direction of the Funeral Direction of the Puneral Direction of the Funeral Direction of the Funeral Dire	edical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	n occurred at the vestigation, in my	time, date an opinion, dea	d place, and th occurred	due to the cat the time, d	ause(s) and late and plac	I manner as ce, and due	stated. to the cause(s)
	To ti withii To ti comp	Me	29b. Signature and title of certifier			nse number		-			h, Day, Year)
•) - 01 avv		444	36		T	4ME	03	2005
(17		30. Name and address of person who completed cause of death (Item 23								
1	10		Ashvin J. Patel, MD, 102 Paul Mel	lon (Court, Su	ite 10	2,Walc	lorf, l	MD-206	502	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 6 2005 32. Registrar's Signature	K.	braile			,		_	
	- negisti	ai .	0011 0 0 2003								

			1 - For State of Maryland / Department of Certificate Certificate			giene leg. No 005	20425
	Physici		1. Decedent's Name (First, Middle, Last) I QVIWG KREIS MAN		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Tor SUBURGAY HOSETAC BETTES	wn, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 062-10-3338 Usual Residence of Decedent	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day 07/24/1		lace (State or Foreign try) York
	uryland show	<u>_</u>	10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	the Ma 28a-f	Director	MD Montgomery N. Bethesda 10e. Street and Number 10f. Zip Co	ode		l0g. Citizen of What Coun	1X Yes 2 No itry?
9	s 1 and 2 should be ifled within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel; or Items 23e or 28e-f show other traumatic event, If it Medical Examination and indifficult at	Funerai	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No TATA T T □	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecity Yes or No-	Jnited State 14. Race - America Black, White,	an Indian, etc.
21215-0036	2 hours aturel', c	ted by	3 Widowed 4 Divorced Year or Dates:	Occupation		Specify: Whi	
1215	within 7: ane. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	done during most of worki retired)	ing	111 1 0	
nd 2	al Hygie I other	Be Co	2 President 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle,	Window Comp Maiden Surname)	any
Maryland	should be and Mental amarked o	2	Leu Kreisman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	Bela Uni		r, City or Town, State, Zip	Code)
	1 and 2 sho Health and em 27 is m		Ruth Kreisman - Wife 11420 Stran	d Dr #7 N. 1	Bethesda		
nore			20a. Method of Disposition 1 \(\mathbb{N}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\mathbb{R}\) Removal from State 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other (Specify)} \) Judean Memorial			20c. Location - City or To	wn, State
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		21. Signature of Funeral Syrvite Licensee 22. Name and A Hines-Ri	Address of Facility naldi Funera w Hampshire	al Home.	Olney, MD	MD 20904
	Physician		23a Part1. Enter he disease, or complications that caused the death. Do not enter the mode or shock, or hart failure. List only one cause on each line. Im ediate use (Final dise condition SUBDUME HEMATIMA				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
,092	death certificate be executed e attending physician and of for use as the burial-transit	ai Examiner	that initiated events resulting in death) Last C				
687	rtificate ng phys as the	Aedicai	d.				
P.O. Box	that the death certifical by the attending philed by the attending philedeached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	ry Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tol	pacco use contribute to the	
al Records,	The ate h page	Completed			24a. Was a autops perform	y prior to con ged? death?	psy findings available inpletion of cause of
Vital	Physicien: The this certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death Other: 4 Nursing Hor		e) ence 6 Other (Specify)
on of	P + P	ion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Gay Year) 1 Injury 28c.		28d. Describe ho	w injury occurred	
Division of	200>	Certification:	2 Accident investigation S Lo CS M S Suicide S Could not be determined S Could n	ffice 2	28f. Location (St City or Town	reet and Number or Rural	Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical Co	29a. Certifier (Cheer any (Cheer any 2) Medical Examiner: On the bast of my knowledge, death occurred at it	the time, date and place, a	and due to the ca	ause(s) and manner as sta	ated.
)	To the within 2 To the complet	Med		icense number	2	9d. Date signed (Month, D	* ' '
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		, no los	352	
¥	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 0 6 2005 32. Segistrar's Signature Apartic	1			

			1 - For State Registrar	ate of M	laryland /		rtment o			Mental Hyg	iene	005	201	126
ı	Physici		1. Decedent's Name (First, Middle, Last)				KRIK	DRI	an/	2. Date of Deal Month		Year 2005	3. Time of	
	/Medic Examir		4a. Facility Name (If not institution, give stree	t and number))		4b. City, To				4c. Co	unty of Death	17700	
			Shady Grove Adventi	st Hos	pital	1	Rockv	ille				ontgome	rv	
	Funeral		5. Social Security Number 6. Sex	7. Ac	ge (In yrs. last	**	If Under 1 Y		Jnder 24 Hr				lace (State or	r Foreign
	Director		093.18.1797 1□M	ZBOF (81	Yrs.	William D	4,0		May 24,	1924		na, NY	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					1	0d. Inside Cit	y Limite
	Mary	Ď	MD Montgom	ery	Darne								1X☐Yes	•
	the	Director	10e. Street and Number				10f. Zip Co	de		1	Da. Citizer	of What Cour	ntry?	
	h with		16416 Montecrest La	ne			20	878				S.A.	,.	
	deat ms 3	Funeral	11. Marital Status	Vas Decedent	Ever in U.S.	13. V	Vas Deceden	of Hispan	ic Origin? (Specify Yes or No-		Race - Americ		
9	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, I'ze Medical Exertiner must be rediffed at	/Fu	1 Never Married 2 Married 1	Yes 25 Yes, Give			Tes, specify ☐ Yes 2 ☐		exican, Pue <i>ecify</i> :	rto Rican, etc.)		Black, White,	etc.	
	ural',	d by	3 Widowed 4 Divorced	ear or Dates:		1					Sp	ecify:		
-2	n 72 h "nat	Completed	15. Decedent's Educatio (Specify only highest grade co		16	6a. Deced (Give I	ent's Usual O kind of work o OO NOT use r	ccupation lone during	g most of w	orking	16b. Kind	of Business/Ind	dustry	
7	filed within 72 Hygiene. hther than "natent, in a Medic	duc	Elementary/Secondary (0-12)	college (1-4or	5+)		cutive				Dent	of Ag	riou1t	1120
0	filed with Hygiene. other than	e Cc	17. Father's Name (First, Middle, Last)			LAC	Cutive			me (First, Middle, A			TICUIL	ure
Maryland 21215-0036	should be f and Mental I s marked of numatic eve	To Be	Vahan Bogosian						A	cdimes Ka	zanji	an		
Mar	alth and 2 sh		19a. Informant's Name/Relationship (Type, I John Krikorian/ Son	Print)						Darnesto				
č Č	es 1 a of He of He r othe		20a. Method of Disposition			of Dispos	ition (Name o	of r place)	1	Date 2	20c. Locati	on - City or To	wn, State	
Ĕ	Page ment ment in the ment in	/	1 ☐ Burial 2 【XCremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	vai from State	Mt.		-	, ,	June	e 13, 2005	Ale	xandria	ı, VA	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menti Important: If item 27 Is marked any injury or other traumatic a <u>once</u> .		21. Signature of Full ral Service Licensee	ors)						seph Gawl				
			23a. Part1 Enter the disease, or complication shock or heart failure. List only one car	ns that caused	d the death. D							JII, 50	Approximate Interval Betw	1990
	Physician		Immediate Cause (Final disease or condition	mitasi	tatic		aut (Onset and De	eath
	/Medical		resulting in death)	Due to (or as	a consequenc			0001	()				year	
	Examiner		Sequentially list conditions, b. —											
	ed tisi	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequenc	ce of):						5.4		
	and and Il-tran	хап	that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):								
8/60	cate be executed physician and the burial-transit				a seriosquorio	JO 01).								
/89	ficate physics the	edical	d									-		
XOX	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	an/Me		yes, outcome							23d	Date of delive	D/	
ň	death e atte d for	icia	in the past 12 months?	Pregnant at	2 ☐ Fetal dea t time of death		Ectopic pregn Other (specif				200.		,	ear
J Ö	t the by the	Physici	9 □ Unknown	Unknown										
S,	w requires that the diplement been signed by the should be detached	by P	Part II. Other significant conditions contribu	ting to death b	out not resulting	g in the un	derlying caus	e given in l	Part I.	23e. Did tob	acco use o	contribute to the	e cause of dea	ath?
or d	en sig	led	3-praventicala	AC	hycai	2017				1 ☐ Ye	2.2 N	o 3 ☐ Proba	ably 4 Un	iknown
ပ	> Q S	ompleted								24a. Was an		b. Were autop	sy findings av	/ailable
	ician: The lav certificate has rector, page 2	Con								perform	ed?	death?		120 01
VItal	ysician: is certific director,	Be (25. Was case referred to medical examiner?					26.	Place of De	ath Check only one	,			
10		P	1 ☐ Yes 2 ♣ No Hospi	Inpatie		Outpatient	3□ DOA		☐ Nursing I	Home 5 Resider	nce 6 🗆	Other (Specify)	
	ing F	on:	· Cartain C C · Circuity	a. Date of Inju (Month, Da	y Year) 28b	n. Time of Injury		injury at Work?		28d. Describe how	v injury oc	curred		
<u> </u>	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	- Dia la:	At he was	4		1 🗌 Yes	2 ∐ No	004.1 - 11 (0)				
JIVISION	or A after Direc in by	Certification:	4 Homicide determined	building, et	ury - At home, c. <i>(Specify)</i>	rarm, stre	et, factory, off	ice		28f. Location (Str. City or Town,	State)	imber or Rural	Route Numbe	∂r,
	spita lours neral filled		29a. Certifier 1 Certifying Physicia	1: To the heet	of my knowled	lge, death	Occurred at the	ne time da	te and alac	and due to the	189(2) 22 1	mannor	atod	
	To the Hospital or Attending Phys within 24 hours attendeath. To the Funeral Director: After this completely filled in by the funeral di	edical	Check only 2 Medical Examiner:	On the basis of and manner sta	t examination a	and/or inve	estigation, in r	ny opinion	, death occi	urred at the time, da	e and plac	mariner as sta ce, and due to	the cause(s)	
	To th To th	95.	29b. Signature and title of certifier				29c. Lic	ense num	ber	29	d. Date sig	ned (Month, E	Day, Year)	
			DOSTLABAIL N	1 D			A	53	717	J	une	1,20	0)	
		f	29b. Signature and title of certifier 30. Name and address of person who completed by the series of person who can be series of person who can be ser	ted cause of d	leath (Item 23a	a) (Type, P	rint)				1			
	5		JOSPHA SAIL NO 10	220 -	rede	11ck	RUM	DE	213	GAITHUS	Dury	MD	2087	7
	Sta	te	31. Date filed (Month Day Year) 6 200	32. Sgistr	ar's Signature	1	arte				1			
i.	Registr	ar		J. A. A.		17					/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

			1 - For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		, ,	ene g. No.	
	Dhysia		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death	21117	3. Time of Death -
	Physic /Medi		FREDERICK	THOM.	AS L	INDSAY		JUNE 5,	2 0 0 5	11:17AM
	Exami	ner	4a. Facility Nam <i>e (If not institution, giv</i> FREDERICK MEM		SPITAL	4b. City, Town, FREDE	or Location of Death RICK		4c. County of Deat	
	Funeral Director			Sex 7. Ag	e (In yrs. last birthda) 70 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan • 15	9. Birt Co 1935 Mar	hplace (State or Foreign unity) yland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary I-f sh	to	Maryland Freder	ick	Thurm	ont				t⊕Yes 2 No
	th the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	41
	ath wi	rai	139 North Carrol	1 Street		217	88		U.S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show wall fujury or other traumatic event, I'm Medical Evaminat must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Arred Forces? 1 Pes 2 In If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	ncan Indian, 9, etc. ite
5	72 hc	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occu	pation during most of work ed)	rina 16	6b. Kind of Business/	Industry
12	withln ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			9	a: a	
р О	filed Hygie othar		17. Father's Name (First, Middle, Last,)	δ.	lgn Craft	,	e (First, Middle, Ma	Sign Co	ompany
an	lid be fental rked c	To Be	Philip Thomas Lin	dsay				h Mary Ha	,	
Maryland	and Nand Is mai		19a. Informant's Name/Relationship (Турө, Print)	19b. Mai	ing Address (Stree	t and Number or Rur	al Route Number, (City or Town, State, Z	Tip Code)
	and 2 ealth m 27		Susan Lindsay (Wi	fe)					ont, MD 2	1788
Baltimore,	it of H it of H if itel or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3 C		20b. Place of Disp cemetery, cre				oc. Location - City or	
Ħ	artmer artmer ortant Injury		'4 ☐ Donation 5 ☐ Other (Specify 21. Sign = Free of Jungral Service Lice		-		rdens 6/8,		ederick, N	•
Ba	Depa Impo any I		Soker C	Telas	1/2	15 EAST I	MAIN ST.,	THURMONT	RAL HOMES	P.A.
I.			23a. Part1. Enter the disease, or comshock, or heart failure. List only	475					t,	Approximate Interval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		unul Thor	ACIC AOR	TIE ANC	urysin		Zyens
F	Examiner		- (Due to (or as a	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	a consequence of):					
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events	C						
30,	oe execian a		resulting in death) Last	Due to (or as a	a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	dica		d						
Box	ath cer ttendir or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	Ectopic pregnanc	у		23d. Date of delice Month	very Day Year
P.0	res that the de signed by the a be detached f	/ Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the i	nderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	quires n sign uld be	d by			lu/monary					bably 4 □Unknown
000	aw requir s been si 2 should b	Completed	CORONARY 1	myeny	DISTAKE			24a. Was an	24b. Were aut	opsy findings available
	Physician: The lav this certificate has al director, page 2	mo						autopsy performe 1 Yes 2	prior to co	ompletion of cause of
Ita	cian: artifica actor, I	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	110 101	20110
7	physic this co	P	1 ☐ Yes 2 ☐ No		nt 2.DER/Outpatie	nt 3□ DOA Oth	aer: 4 ☐ Nursing Ho	me 5 🗆 Residenc	e 6 □Other (Speci	fy)
u	ding F h. After funera	ion:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injur Wor	y at rk?	28d. Describe how	injury occurred	
Division of Vital	after death. after death. I Diractor: A d in by the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ry - At home, farm, st		Yes 2 □ No	28f Location /Stree	et and Number or Run	al Pauta Mumbas
2	al or / s after Il Dira	Certification:	4 Homicide determined	building, etc.	. (Specify)	cot, factory, office		City or Town, S	State)	ar noute ivumper,
	To the Hospital of within 24 hours at To the Funaral D completely filled it	Medical C	Check only 2 Medicel Exam	ysician: To the best o	examination and/or in	h occurred at the tir	me, date and place, a	and due to the caus	se(s) and manner as s	stated.
	o the ithin 2 o the omple	Med	one) 29b. Signature and title of certifier	and manner stat	tød.	29c. Licens			Date signed (Month,	
	_		7751	~ MA			035/52	230.	La La La La La La La La La La La La La L	05
^	×	}	30. Name and address of person who o	completed cause of de	ath (Item 23a) (Type				0/0/0	/ -
<	\		J.L. Kranz,	MD.	100 5.	Conser	Si Th.	is mint, 1	NO 2178	8
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Registra	r's Signature	South?				

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I		and Mental	Hygier	ZUID	204	28
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date Mont	of Death	Day Year	3. Time of D)eath
	Physici /Medio		Dorothy Lambdin					June		005	1:00	A^{M}
	Examir	ıer	4a. Facility Name (If not institution, give	street and number	7)	4b. City, Town, o	or Location o	of Death		4c. County of Death		
			21 Elm Street			Thur		2411		Frederick		
н	Funeral Director		5. Social Security Number 6. Se	x /.A]M 2⊠F	ge (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days			th Day Yes	ari Coun	ace (State or I try)	Foreign
			217-28-5436 Usual Residence of Decedent		7.5			June	2/,	1931 Mary1	and	
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				11	Od. Inside City	Limits
	a-f sl	tor	Maryland Frederi	ck	Thurmon	t					1 ☑ Yes 2	2 🗌 No
	or death with the Marylan tems 23s or 28s-f show sermust be notified at	Director	10e. Street and Number			10f. Zip Code			10g. (Citizen of What Coun	try?	
	23a 23a		21 Elm Street			21788			Uı	nited Stat	es	
	Items	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	Was Decedent of H	Hispanic Orig	gin? (Specify Yes		14. Race - America Black, White, 6	an Indian,	
36	or h	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	No	1 ☐ Yes 2 ☑ No		, r s s r r r r s s r r s s r r s s r	,	Specity: Whi		
Ö	within 72 hours after death with the Maryland ene. than 'naturel', or items 23a or 28a-f show he Modical Exand ser must be notified at		3 Widowed 4 Divorced	Year or Dates:								
15	in 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	16b.	Kind of Business/Ind	ustry	
12	iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+	5+) Teacl		ter		, I	Education		
p	be filed within 72 hours afte ital Hygiene. id other than "natural", or l event, the Medical Examil	Be C	17. Father's Name (First, Middle, Last)		, , , ,	101 / 1111		r's Name (First, M				
<u>lar</u>	Mental arked c	To B	Russell Snyder				Mary	Allnut				
an	2 should be and Mental le marked aumatic ev		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailie	ng Address (Street	and Numbe	r or Rural Route N	lumber, City	y or Town, State, Zip	Code)	
≥ `	D 5 ~ =		Robert Lambdin / H	lusband	21 E	lm Street	, Thu	rmont, M	2178	38		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 le marke any injury or other traumatic ance.	1	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other pla	сө)	Date	20c.	Location - City or To	vn, State	
Ë	. Pag tment tant: jury		' 4 ☐ Donation 5 ☐ Other (Specify)		Resthaver			une 6, 200	05 Fre	ederick, M	aryland	d
Bal	Depar Depar Impor Impor Impor Impor		21. Signature of 5 neurol Licens	6	Re	2. Name and Addre	ss of Facility Funera	al Servi	ces, S	Skkot Cody	P.A.	
	40200				9.5	OI Catoc	tin Mt	tn. Hwy.	Frede	erick, MD	21701	
l,			23a. Part1. Enter the disease, or complete shock, or heart failure. List only of	ne cause on each l	line.	er the mode of dyir	ng, such as	cardiac or respirat	ory arrest,	P	Approximate Interval Between Onset and Dea	en
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	3	mon 8	mulf	a	M	19 (le		
	Examiner			Due to (or as	s a consequence of):							
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as	s a consequence of):							
	icate be executed physician and s the burial-transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events									
Ó	an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):							
8760,	cate be executed physician and the burial-transit	dlcal		1.						L.		
39	ntifica ing ph e as t	Med	IF FEMALE:									
Box	death certific e attending pl d for use as t	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy	,			23d. Date of deliver	*	
o.	0 0 0	Physician/Me	1 Yes 2 No	4□ Pregnant a 9□ Unknown	t time of death 5	Other (specify) _				Month [Day Yea	21
<u>α</u>	The law requires that the te has been signed by thoage 2 should be detached.	P	Part II. Other significant conditions cor	atributing to death I	but not resulting in the u	adorhina equeo an	on in Bart I	230	Did tobacco	use contribute to the		ab 2
Vital Records,	signed d be det	d by		in g to count	out not rooming in the di	identyling cause giv	on arranti.		1 ☐ Yes		bly 4 Unk	
S	w requir been si should	ete										
Re	The fav	Completed							Was an autopsy performed?	24b. Were autop prior to com death?	sy findings ava pletion of caus	ailable se of
			25. Was case referred to medical					1 🗆 Y	es 22N	lo 1 🗆 Yes 2	P.□ No	
		To Be	examiner?	lospital:	ent 2 ER/Outpatien	t 30 DOA Oth		of Death Check of	, , , , , , , , , , , , , , , , , , , ,	6 ☐Other (Specify)		
0	ig Phys ter this neral di	iii	27. Manner of Death	28a. Date of Inju	ury 28b. Time of					ury occurred		
<u>.</u>	를 잘 할	atlo	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOITH), Da	ay Year) Injury		k? Yes 2∐N	lo				
Division of	or Atten after deatl Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, farm, stretc. (Specify)	eet, factory, office			on (Street a	and Number or Rural	Route Number	r,
Ω	ital o irs aff ral Di lled ir									,		1
	Hosp 14 hos Fune Fune	edical	(Check only 2 Medicel Examil	1er: On the basis o	of my knowledge, death of examination and/or inv	occurred at the ting	ne, date and pinion, death	place, and due to	the cause(s) and manner as sta	ted. he cause(s)	
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Med	*29b. Signature and title of certifier	and manner st	ated.							
	F 18 F 8		Signature and the or certifier	OL		7)	754	9		ate signed (Month, D	ay, 1847)	
	5		30. Name and address of person who co	moleted cause of	death (Itom 32s) (Time		, ,	,	6	7 7 7 7		
			William F. Harper				r C+	101	EroJ.	wiel- MD (1700	
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signature	,	1., 50	.e. 101,	rreae	IICK, MD	21/02	
	Registra	ar	JUN 0 7 200	15	w B B	and!						

WILLIAM A. LYSTER

Please Type or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

			1 - For State Registrar		ryland / Dep		t of H	ealth a		ental Hyg	_	U5	201.29
	Physici	an	1. Decedent's Name (First, Middle, I	Last)						2. Date of Dea Month		Year	3. Time of Death
	/Media		WILLIAM ALONZO							JUNE	NE 2 2005 7:1		
	Examir	ner	4a. Facility Name (If not institution, g 2051 Bainbridge				Town, or dorf	Location o	f Death		4c. County		
	Funeral	_		. Sex 7. Age	(In yrs. last birthday) If Under	1 Year	If Under 2		8. Date of Birth			place (State or Foreign
	Director		008-14-6468	1½M 2□F (31 Yrs.	Months	Days	Hours	Min.	(Month, Day, July 10		Vir	ginia
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation					-	1	Od. Inside City Limits
	Mary e-f sh	tor	Maryland Charl	es	Waldorf								1 XYes 2 ☐ No
	or 28e	irec	10e. Street and Number			10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?
	ath wi	rai	2051 Bainbridge	· · · · · · · · · · · · · · · · · · ·				602			Ţ	JSA	
	Item de	une	11. Marital Status	12. Was Decedent E Armed Forces?	i i	. Was Deced If Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ ck, White,	ean Indian, etc.
99	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show disal Examener wet be notified at	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 17 Yes 2 □ No If Yes, Give Year or Dates:		1□ Yes 2	No No	Specify:			Specif	v: Wh	ite
5-0	72 ho	Completed by Funeral Director	15. Decedent's (Specify only highest of	Education	16a. Dec	edent's Usua	l Occupa	tion	of workin	a l	16b. Kind of B	usiness/In	dustry
12	within ane. then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	-)	e kind of wor DO NOT us	e retired,	1	0, 110,111		**7	~	
Maryland 21215-0036	filed y Hygie other i		17. Father's Name (First, Middle, Lat	5+ st)	Den	tist		18. Mother	r's Name	(First, Middle, I	Health		e
<u>a</u>	fental fental rked c	To Be	Merton E. Lyster							kson Ly		,	
ary	and N and N is ma		19a. Informant's Name/Relationship	(Type, Print)						Route Number			Code)
	and sealth m 27 m		Patricia M. Lyst	er (wife)			_			dorf, M			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Di partment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28e-f show any injury or other treumetic event, the Medical Expirator usit be notified at our		20a. Method of Disposition 1 ☐ Bural 2 🎇 Cremation 3		20b. Place of Disp cemetery, cre	osition (Name matory or of	ne of ther place)			20c. Location -		
	artme artme ortani injury		* 4 □ Donation 5 □ Other (Spec		Metropol	2. Name and		T.		05	Alexar	IGI I a	, VA
Ba	De per per per per per per per per per pe		> steelt	M0017	3				Ebe	rwein F White P	uneral	Serv	ices
			23a. Part Enter the disease, or co	mplications that caused to be one cause on each line	he death. Do not er	iter the mode	of dying	, such as	cardiac or	respiratory arre	до , гш. est,	200	Approximate Interval Between
	Physician	ř	Imm-qui te Cause (Final disea e or condition		Paul								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	cosequence ob:	٨	<	0					
		į.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	ple	<u></u>	Luo	240			_	
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	_	4-01100 01/1	~							
oʻ	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d						-			
×	eath certifica attending pt for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of	f pre <i>a</i> nancy								
ROX	death a atten d for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pre <i>g</i> nant at ti	Fetal death 3	⊒Ectopic pre					23d. Dai	te of delive nth	ny D ay Year
<u>о</u>	at the de by the a tached	hysi	9 Unknown	9□ Unknown			,,						
_	s this	by	Part II. Other significant conditions	contributing to death but	not resulting in the	anderlying ca	use give	n in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?
o O	w require been sig should b	eted								1 🗆 Ye	s 2 No	3 Prob	ably 4 Unknown
Hecords ,	The law cate has b	Comple								24a. Was ar autopsy perform	/ 5	prior to con	osy findings available npletion of cause of
_		e Co	25. Was case referred to medical							1 ☐ Yes 2	Mo 1	leath?	2 No
Vital	dis y	To B	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DO				Check only one		ar (Specific	
0	ding Ph h. After the funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day			c. Injury Work	at		d. Describe ho			,
DIVISION OF	ttendi death. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not	on be		М		es 2□N	-				
<u> </u>	after death	ertification;	4 Homicide determine	d 28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory,	office		28	If. Location (Str. City or Town,	eet and Numb , State)	er or Rurai	Route Number,
	Hospitel	O	29a. Certifier Certifying P	Physician: To the best of	my knowledge, dea	h occurred a	t the time	e, date and	place, ar	nd due to the ca	use(s) and ma	nner as sta	ated.
	To the Hospitel of within 24 hours all To the Funerel D completely filled in	edical	(Check only a Medical Exa	aminer: On the basis of e and manner state	xamination and/or ir	ivestigation,	in my opi	nion, death	occurred	d at the time, da	te and place, a	and due to	the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	1-1-R	٨		License			29	d. Date signed		
1				Jul 1 Ju	den		70(2010	4 OC		6-3	-05	
1	R		30. Name and address of person who Henry L. Burke I			•	'a D.	lata	MT) 1	20646			
	Sta	te	31. Date filed (Month, Day, Year)	20 Paretrari	s Signaturo			Luva,	, LU 2	20020			
	Registra	ar	JUN 0 6	2005	w If	pera							

				partment of Health and Mental lertificate of Death	Hygiene 005	20430
			Decedent's Name (First, Middle, Last)	2. Date of	f Death	3. Time of Death
4	Physici /Medi		Stephen A. Liberatore	Month JUNE		1230 P ^M
	Examir		4a. Facility Name (If not institution, give street and number) 1 LAVALETTE DRIVE	4b. City, Town, or Location of Death CRISFIELD	4c. County of De SOMERSE	ath
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month)		irthplace (State or Foreign
	Director		578-74-5046 1 [™] 2□F 51 Yrs.		00	lew York
	pud 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	position		10d. Inside City Limits
	sho ed et	2		Socialion		1 Yes 2 No
	h the Maryland r 28a-f show	Director	Maryland Montgomery 10e. Street and Number	Silver Spring	10- Chinas of Mines	
	with a or	ä	1026 Woodside Parkway		10g. Citizen of What C	Country?
	death with the Maryland ms 23a or 28a-f show froust be notified at	Funeral		20910 Was Decedent of Hispanic Origin? (Specify Yes o	r No- 14. Race - Am	
10		F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Mo	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wh	
980	hours after death with ural, or items 23a or al Examiner must be	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No Specify:	Specify: Wh	ite
21215-0036	n 72 hours "natural", edical Ex	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working	16b, Kind of Busines	s/Industry
2	within ene.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	ygien ygien yer th	Con		nancial Advisor	Financ	e
nd	be filed withing tal Hygiene. Id other than event. It sim	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	ddle, Maiden Sumame)	
<u>y</u> ia	Men Marke arke	은	Salvatore Liberatore	Frances Cr		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, Ine Mes			ing Address (Street and Number or Rural Route No		
	l and lealth im 27 ther t		Virginia B. Liberatore/ Wife 1020 20a. Method of Disposition 20b. Place of Disp	Woodside Parkway, Sil	ver Spring,	MD 20910
Baltimore,	nt of h		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place) June 8	20c. Location - City o	r Town, State
Ę	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke injury or other traumatic.			even Cemetery 2005	Silver Spr:	ing,Maryland
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Mayus 5 Cooky	Anneand Address of Facility Reviews Funera OO University Blvd, W.,	Silver Sprin	ng,MD 20901
			23a. Part1. Exter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respirato	ry arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		-	Sequentially list conditions, b.			
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
В.	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	icate be e. physician s the buria	dicai E				
	ficate g phy: as the	0	o.			
Вох	death certific e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- -	23d. Date of de	elivery
œ.	0 0 0	icia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month	Day Year
P.0	that the di ed by the detached	hys	9 Unknown			-
S,	The law requires that the te has been signed by thoses should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. D	id tobacco use contribute t	o the cause of death?
Records,	w requir been si should	Completed by		1	☐ Yes 2☐ No 3☐ P	robably 4 Dunknown
ec	e law r has be ge 2 sh	ple		24a. V	Vas an 24b. Were a utopsy prior to	utopsy findings available completion of cause of
		Con		_ p	erformed? death? es 2 □ No 1 🖼 Yes	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)	
of	Physi this c ral dire	2	1 Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatie			acify) AT SCENE
	ing F	OU:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	Work? V C /a.	be how injury occurred	D- 4
Sic	Attending ir death. ector: After by the funer	cat	10 Could not be force of 13/01 1 and	TAS 1 Yes 2 No	7	es culting
Division	or A after Direction by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location City or	n (Street and Number or A Town, State)	Pett brie
	pital ours s eral filled	2	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea	ted one of home cris	tilly, Many	10.0
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, dea 2√2 Medical Examiner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place, and due to evestigation, in my opinion, death occurred at the time.	the cause(s) and manner a ne, date and place, and du	s stated. e to the cause(s)
	vithin o the	Me	29b. Signature and title of certifier	29c. License number OCME	29d. Date signed (Mon.	th, Day, Year)
	10		11/10/11/	OCFIE	JUNE 4, 20	005
•	(0	-	30. Name and address of person who completed cause of beath (Item 23a) (Type	Print)		
			THE MURE Milling	111 Penn Street Bal	timore, Maryl	land 21201
	Sta	te	Of Date Flad (Month Day Voor)	(/ »		
	Registr	ar	JUN 0 6 2005	me		

				gpe or Print in Black in State of Maryland / Depa Cei		_	ne 2005 20131			
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death			
	Physicia	an			7	_	Day Year			
	/Medic		Alfred B. Lonesome		4b. City, Town, or Location of Death	une 3	3 2005 1:04 P M 4c. County of Death			
	Examin	er	4a. Facility Name (If not institution, give s Holy Cross Hospit		Silver Spring		Montgomery			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes NOV 29,	9. Birthplace (State or Foreign Country)			
	Director		093-12-6066 1⊠ Usual Residence of Decedent	M 2□ F 82 Yrs.	Months Days Flours Will.	Nov. 29,	1922 Maryland			
	nyland how		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits			
	Ba-fs	cto		gomery Whe	aton		1 ☐ Yes 2 🔀 No			
	or 2	Dire	10e. Street and Number	3	10f. Zip Code	10g.	Citizen of What Country?			
	s 23s	stal	12105 Goodhill Ro		20902	rifu Vee or No-	USA 14. Race - American Indian,			
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. Important: I flem 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, It a Modical Examination is to notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ XYes 2 □ No	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 No Specify:	lican, etc.)	Black, White, etc. Specify:White			
2-00	72 hou natura	Completed by	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation kind of work done during most of workin	a 16b.	. Kind of Business/Industry			
21215-0036	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired) ld Editor		deral Government			
2	Hygie Hygie nt, II		17. Father's Name (First, Middle, Last)	тте	18. Mother's Name					
land	12 should be filed within and Mental Hygiene. 7 is marked other than "rearmatic event, Ine Mad	To Be	John Lee Lonesome	2		Williams				
Maryland	2 shou and N is ma		19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Rural					
<u>ح</u>	l and fealth im 27 her t		Margarita M. Lones	20b. Place of Dispo	5 Goodhill Road, W.	-	ID 20902 Location - City or Town, State			
nor	ages into the tribute of tribute of the tribute of tribute of tribute of tribute of the tribute of trib		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State cemetery, crei	ven Cemetery 20	e 7,	ver Spring, Maryland			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		21. Signature of Funeral Service License	F.T.	Name and Address of Tableyns For University Blvd,	uneral Ho	me Inc			
	40244		23a. Part 1. Enter the disease, or com-	cations that caused the death. Do not ent			Approximate			
F	hysician /Medical		shock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death)	Cirrhosis of Liv			Interval Between Onset and Death			
	Examiner			Due to (or as a consequence of): Primary Sclerosi:	ng Cholangitis					
	it of	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).						
	te be executed ysician and ne buriat-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):						
	ate be e nysiciar he buri	cal	d							
68	artifica ing ph e as ti	Med	IF FEMALE:							
	ne death certificate the the attending physiched for use as the b	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year,			
<u>α</u>	that the de led by the detached	y Ph	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?			
Records,	requires that the een signed by th hould be detache	ed by				1 🗆 Yes	2 No 3 Probably 4X Unknown			
ပ္သ	~ 9 %	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
	9 T B	E				performed	? death?			
	ician: Th certificate rector, pag	O	25. Was case referred to medical		26. Place of Death					
>	ysici is ce direc	OB	examiner? 1 ☐ Yes 2 😨 No	ospital: 1 ☐ Inpatient 2 ☑ ER/Outpatier	nt 3 DOA Other: 4 Nursing Hom	e 5 Residence	6 ☐Other (Specify)			
o uc	ding Ph h. After th funeral	tion: T	27. Manner of Death 1 ★Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	njury occurred			
Division	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	8l. Location (Street City or Town, St	and Number or Rural Route Number, ate)			
	e Hospil 124 hour e Funera letely fills	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, deat ler: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)			
	To th Within To th Compl	Me	29b. Signature and title of certifie	D/ A	29c. License number	29d.	Date signed (Month, Day, Year)			
_4	5+1		1 Ste G	MD	D24348		06.03.2005			
			30. Name and address of person who co Steven Grufferman	mpleted cause of death (Item 23a) (Type, . M.D. 1500 Fores	Print) t Glen Road, Silven	r Spring,	MD 20910			
		te	31. Date liled (Month Day, Year) 6 20	32. Jegistrar's Signature						

			For	State of Maryla	and / Depa	artment of H	ealth and M	•		3	201	00	
1.0			1 - State Registrar Amend#'s 5.20	o.& 20c.PerInf.P	CC 6-14-8	gifiçate of L	Death		Reg. No	6. 000		+32	
Gim	Physici /Medio		Decedent's Name (First, Middle, La SHIRLEY	st)	AWRENCE	,		2. Date of De Month JUNE	ath Da	y 2005	3. Time of 2:08	Death A M	
	Examir	ner	4a. Facility Name (If not institution, giv				Location of Death			. County of Deeth	DORIC		
			GLADYS SPELLMAI 5. Social Security Number 6. S		rs. last birthday)	HYATTSV.	LLLE If Under 24 Hrs.	8. Date of Bir		RINCE GEO		r Fornian	
ŀ.	Funeral Director		COO OA ECOE	1□M 2□F 48	Yrs.	Months Days	Hours Min.	MAY 26	19.	57 NORTH	otace (Stete ontry) H CARO	LINA	
	death with the Maryland ms 23a or 28a-f show fiftual be ricilled at		10a. State 10b. County	10c.	City, Town or Lo	ocation				1	IOd. Inside Ci	ty Limits	
	a-f st	cto	DC	WA	SHINGTO	N,DC					1 X Yes	2 🗌 No	
:	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cour	ntry?		
;	ath w	ral	3507 JAY STREET			20019				.S.A.			
	Itam Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 [X] Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White,			
2-0036	n /2 hours atter death with the Marylan "natural", or items 23e or 28e-f show	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:				LACK		
'n	onation /2 in	lete	15. Decedent's Education (Specify only highest gradual)	ducation ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired.	luring most of work	ing	16b. K	ind of Business/In-	dustry		
717	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSI				PR	IVATE			
	a tiled Il Hygi other	BeC	17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle,					
yland	should be nd Mental s marked o umatic eve	To B	LINWOOD LAWI	RENCE			JOSEPHI	NE M. F	OMPI	ΕY			
Jar	nd 2 sh lith and 27 is m r treum		19a. Informant's Name/Relationship (19b. Mailir 3507	ng Address (Street a JAY ST. I	nd Number or Run N.E. #10	al Route Number	er, City o	or Town, State, Zip	Code) 20019		
ַטַ י	Peges 1 and 1 nent of Health int: if Item 27 iry or other tr		20a. Method of Disposition 1 ဩ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Dispo	sition (Name of natory or other place	6/9/	Oate		pocation - City or To			
	permit. Peges Department of Important: if it any injury or o		21. Signa de de Luperal Service Licer			2. Name and Addres		1		FUNERAL			
ñ				3	7	474 LANDO						ó	
	Don't		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not ent	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Bety	ween	
	hysician		Immediate Cause (Finat disease or condition	Klebsiel	la Sept	icemia					Onset and D)eath	
	/Medical Examiner		resulting in death)	Due to (or as a cons	, ,								
		<u>-</u>	Sequentially list conditions,	b. Respirat		lure							
3	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Lupus	31100 0.7.								
5	le be executed ysician and e burial-transit	Exa	that initiated events resulting in death) Last	Oue to (or as a cons	equence of):								
2/00,	are be nysicia he bui	Ical		Decubitu Decubitu	s Uclers	3							
00	centificate iding phys ise as the	Med	IF FEMALE:										
	e atter	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetet death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						23d. Date of delivery Month Day Year		
ŗ	iaw requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions of	contributing to death but not	esulting in the un	nderlying cause give	n in Part I.	23e. Did to	obacco L	use contribute to th	ne cause of de	eath?	
cords	n sign	d by						101	Yes 2	□No 3□Prob	ably 4X0	Inknown	
0 0 10	s been sig	Completed						24a. Was	an	24b. Were auto	psy findings a	available	
ב י	ine law ate has page 2 s	E O						autop perfo 1 Yes	rmed?	prior to cor	mpletion of ca	iuse of	
		Bec	25. Was case referred to medical examiner?				26. Place of Death			7,3,163	2,10		
5	this ce	10	1 ☐ Yes 2X No		☐ ER/Outpatien		4 M Nursing Ho	me 5 Resid	dence	6 □Other (Specif)	v)		
O HOISIN	Attending Physician: r death. sctor: After this certific. by the funeral director,	atlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Work	at ? ′es 2 □ No	28d. Describe I	now injur	y occurred			
=	after de I Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (5 City or Tox	Street an vn, State	d Number or Rura)	l Route Numb)e <i>r</i> ,	
	to the nospital or Attention within 24 hours after death. To the 24 hours after death. completely filled in by the funer.	edical C	29a. Certifier 1 X Certifying Ph (Check only one)	nysician: To the best of my k niner: On the basis of exam and manner stated.	nowledge, death nation and/or inv	n occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the	cause(s) date and	and manner as st place, and due to	ated, the cause(s)		
	To the	Me	29b. Signature and title of certifier	<i>5</i>)		29c. License	number		29d. Dat	e signed (Month,	Day, Year)		
,			TAMA	Mas		D002	6024		Ju	ne 3,	2005		
/	DE		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)							
(1160		Lester Miles M.D				Landover,	, Maryla	and	20785	-		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	inature								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) o Physician 2. Date of Death 3. Time of Death Day Month Year Betty Ann Maidens 2005 /Medical June 1:10 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Vindobona Nursing Home

5. Social Security Number 6. Sex Braddock Heights
If Under 1 Year | If Under 24 Hrs. Frederick 8. Date of Birth Month, Day, Year Feb. 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Country)
Illinois Days Min. Months Hours 1 ☐ M 2 🂢 F Director Yrs. 578-12-4098 86 1919 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State show 10b. County 10c. City, Town or Location iem 27 is marked other than "netural", or items 23a or 28e-1 show other treumetic event. It a Madical Evantinal mi 10d. Inside City Limits Director 1 ☐ Yes 2 No WV Jefferson Charles Town 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 825 Tuscawilla Hills Funerai 25414 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√ No 3 TWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill thent of Health and Mental Hy tent: If item 27 is marked oth jury or other treumetic even 18. Mother's Name (First, Middle, Maiden Sumame) Be William J. Brenner Grace Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Norris - Daughter er 620 - 5th Avenue - Brunswick,

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 21 MD 21716 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Hagerstown Crematory 6/7/2005 Ha erstown, MD 22. Name and Address of Facility Eackles-Spencer Funeral Home 21. Signature of Funeral Service Licensee Rold X 23a. Part1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M970 Harpers Ferry, WV 25425 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a confequence of): disease or condition resulting in death) dodors minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown as been signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1□Yes 2√2No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 41 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD056890 30. Name and address of person who completed cause of death (Item 23a) (Typę, Print) 5 Gessert 610 wenue Bruswick 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State 2005

Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 Pag. No. 2005 Reg. No. 2005 Pag. No. 2005	
	Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Last) ASO 1. Decedent's Name (First, Middle, Last) ASO 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death	М
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 (Hoder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 (Month, Day, Year) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (State or Foreign Country) 1 (Month, Day, Year) 2 (Month, Day, Year) 2 (Month, Day, Year) 3 (Month, Day, Year) 4 (Month, Day, Ye	gn
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dicel Evand at must be reditied at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Ellicott City 1 □ Yes 2√2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
9600	hours after death ural', or Items 23 Il Examinant trus	b	9310 Joey Drive 11. Marital Status 1 Never Married 2 Married 2 Married 3 No lf Yes, Give Year or Dates: 1933-37 1 Never Married 2 No lf Yes, Give Year or Dates: 1933-37 1 Never Married 2 No lf Yes, Give Year or Dates: 1933-37 1 Never Married 2 No Specify: 1 Never Married 2	
nd 21215-0036	filed within Hyglene. ther then int, the Me	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Immigration Official 18. Mother's Name (First, Middle, Last) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Non OFFICIAL 17. Father's Name (First, Middle, Last)	
Maryland	12 should h and Mer 7 is marke treumatic	ToE	J. Roy Mason L. Madge Silvers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Mason/Son 3126 Elmmede Road Ellicott City, MD 21042	
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: It Item 27 eny injury or other tre 0000.		20a. Method of Disposition 1	
ı	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease or condition. Approximate Interval Between Onset and Death of CREAT CARCINO MA	
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	a. Due to (or as a consequence of): Due to (or as a consequence of):	2
.O. Box 6	death certif e attending id for use a	Physiclan/Medical	FFEMALE: 23c. If yes, outcome of pregnancy 1	
cords, P.		Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b: Were autopsy findings available	_
Vita	Physicien: The lav this certificate has ral director, page 2 is	To Be Comp	autopsy performed death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	
/ision	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification: T	17. Manner of Death 1	
۵	To the Hospitel o within 24 hours at To the Funerel D completely filled in	Medical Cer	29a. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
20	5 Twit		29c. License number 29d. Date signed (Month, Day, Year) 29c. Name and address of Cerson who completed cause of death (Item 23a) (Type, Print)	
	Sta Registr		JUN 0 7 2005 STAPP (FONT) 32. Registrar's Signature 32. Registrar's Signature 4. Aprel 1. Date filed (Month, Day, Year) 32. Registrar's Signature	a

			1 = State Registrar	State of Man		epartme Certifica			nd Me		giene Reg. No.	005	20	435
			1. Decedent's Name (First, Middle, Last,						2	2. Date of Dea	ath Day	Year	3. Time	ot Death
	Physici /Medic		Helene Elizabet	h McCarthy					J	June	2	2005	5:55	р м
	Examin		4a. Facility Name (If not institution, give	street and number)	-	4b. Ci	y, Town, or	Location of	Death		4c. (County of Deat	1	
			Montgomery Gene				01n				M	ontgome	ery	
	Funeral		Social Security Number 6. Security Number	7. Age (i M 2√g F	in yrs. last birtl	Month	ter 1 Year s Days	Hours	Min.	B. Date of Birt (Month, Day	h y, Yea <i>r</i>)	9. Birti	nplace (State untry)	e or Foreign
	Director		579-05-2315		95	rs.			N	Nov. 8,	190	9 Mich	igan	
	and w	}	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location					-		10d. Inside	City Limits
	danyl f sho	ō	26 7 1 1 26									:	1 🖺 Y€	es 2√2 No
	the 28a-	Director	Maryland Montgome 10e. Street and Number	ry		ilver	SPTIN Zip Code	<u>g</u>			10g. Citiz	en of What Co	untry?	
	3e or	Ö	14400 Homecrest Ro	ad #43			2	0906				USA		
	ms 2	era	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Dec			in? (Spec	ify Yes or No- ican, etc.)		4. Race - Ame		
9	or ite	by Funeral	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give			2⊠ No	Specify:	ruento ni	ican, etc.)		Black, White	e, etc.	
93	rai',	l by	3 XWidowed 4 ☐ Divorced	Year or Dates:		10163	2 22 140	зреспу.				Specify: Wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "netural", or items 23e or 28a-f show ant, I've Mydical Evar, it at must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>		Decedent's U	work done o	during most of	of working	,	16b. Kin	d of Business/l	ndustry	
2	nithin ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO1)						
7	led v tygie her t		12 17. Father's Name (First, Middle, Last)		Ho	memake	r	18 Mother	's Name /	First, Middle,	Own Maiden			
anc	htal H	Be		-					,					
ž	d Mer mark matic	2	James Campbel 19a, Informant's Name/Relationship (T)		19h	Mailing Addre	es (Stroot :		eviev		emp1	econ Town, State, 2	in Code)	
Maryland	d2st than 7 is r traur													
	1 an Heal Heal		John F. McCarthy 20a. Method of Disposition	Son	20b. Place of	05 Vic Disposition (A	lame of		arnes Da	te town, M		and 20 ation - City or	0878 Town, State	
noi	ages ent of it: if if		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Metrop					2005	4.7	1 .		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural; or items 23e or 28a-f show empty or other traumatic event, the Madical Evan institute notified at ODGS.		21. Signature of Juneral Service Licens	90 0 -		22. Name		s of Facility				andria,	-	nia
Ba	Dep Imp eny eny		* (mohen)	Jole		Franc	is J.	Colli	ins F	uneral	Hom	e, Inc. Spring	. MTD 2	0001
			23a. Part1. Enter the disease, or compl	ications that caused th	e death. Do n	ot enter the m	ode of dyin	g, such as c	ardiac or	respiratory ar	rest,	Spring	Approxim Interval B	ate
	Physician		shock, or heart failure. List only be immediate Cause (Final		1	0 . 11		1	D •				Onset an	d Death
	/Medical		disease or condition resulting in death)	Arteriosc. Due to (or as a c			ovasc	ular 1	Disea	ise			year	S
L	Examiner		Conventially list conditions	2										
L	p ≓	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence o	t):								
	cate be executed by sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·										
90,	oe exectan sourial.	Ē	resulting in doutin, cast	Due to (or as a c	onsequence o	():								
8760,	physic	dicat		d										
9 x	death certific e attending p id for use as	/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy						20	3d. Date of deli	.0.01	
Вох	atten for u	ian	in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tim	Fetal death	3 □Ectopic 5 □ Other					-	Month	Day	Year
o.	0 0 0	ysi	1 Yes 2 No 9 Unknown	9□ Unknown										
Ф.	The law requires that the site has been signed by the bage 2 should be detache	Completed by Physician/Me	Part II. Other significant conditions co.	ntributing to death but r	not resulting in	the underlyin	g cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause o	f death?
rds	quire:	d be	Renal Failure							1 🗆 Y	′es 2∑	No 3□Pro	bably 4 [Unknown
00	aw require s been si 2 should b	plet	Chronic Obstruct	ive Pulmona	arv Dis	ease				24a. Was		24b. Were au	opsy tinding	s available
Ä	The lav	E O								autop perfor	rmed?	death?	2 No	04430 01
ital		Be C	25. Was case reterred to medical					26. Place	of Death (Check only o				
f V	Physiclen: r this certific ral director,	ToE	examiner? 1 Tes 2 No	lospital: 1 🔀 Inpatient	2 ER/Out	patient 3	DOA Othe	er: 4 ☐ Nurs	sing Home	e 5 🗆 Resid	lence 6	□Other (Spec	ify)	
0	ding Physicien: h. After this certific funeral director,		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Ti	jury	28c. Injury Work	ς?		ld. Describe h	ow injury	occurred		
Sio	ttendi death. ctor: A / the fu	cati	2 Accident investigation			M		Yes 2 □N						
Division of Vital Records,	or Ati fiter d Sirect on by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place ot Injury building, etc. (- At home, tan <i>Specify)</i>	m, street, tact	ory, office		28	City or Tow		Number or Ru	al Houte Ni	umber,
	pitei urs a erai [20 O VIII O O O O O O O O O O O O O O O O	alaia - T- Ab - b - A -A		-d	1 441 = 5							
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		sicien: To the best of r ner: On the basis of ex and manner stated	camination and									e(s)
	o the	Me	29b. Signature and title of certifier			1	29c. License	number			29d. Date	signed (Month	Day, Year	}
)			Dexin Arru	mi, AS	-		D08	3381			June	3, 200	5	
	10		30. Name and address of person who co	ompleted cause of deat	th (Item 23a) (1	Type, Print)								
			Benjamins Avrunin				hilip	Drive	e_ 01	nev. M	arv1	and 20	832	
	Sta		31. Date tiled (Month, Day, Year)	32 Pagistrar's	Signatura	book	0							
	Registr	ar	JUN 0 6 2	UUJ MANA	1									

			1 - For State Registrar	State of Mar		artment of Fertificate of			giene Reg. No.	
	Physic /Medi	čal.	Decedent's Name (First, Middle, La Facility Name (If not institution on)	Donna Ka	y Mundey	de Cita Tana		2. Date of De Month	Day Y	00 011
	Exami	ner	4a. Facility Name (If not institution, giv Washington County 5. Social Security Number 6. S	Hospital	'In yrs. last birthday	Hag	r Location of Death serstown If Under 24 Hrs.	8. Date of Bin		ington
L	Funeral Director		219/54/2499 Usual Residence of Decedent	□ M 2 □ X F	54 Yrs.	Months Days	Hours Min.	(Month, Da	18,1950	Birthplace (State or Foreign Country) Maryland
	ne Marylan 8a-f show diffed at	Director	10a. State 10b. County Maryland Washing		0c. City, Town or L	Hagerst	own			10d. Inside City Limits 1 X Yes 2 □ No
	s 23a or 2	eral Dire	10e. Street and Number 839 Pine Street				740		U.S.A.	
9036	id 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventh or things to mainlined at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. White
21215-0036	filed within 72 h Hygiene. other than "natu ant, the Medical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup e kind of work done DO NOT use retired Machinist	during most of worki d)		16b. Kind of Busin	
Maryland 2	should be filed ind Mental Hygid i markad other umatic avant, I	To Be Co	17. Father's Name (First, Middle, Last) Clyde W. Higgs			Machinist	18. Mother's Name	(First, Middle,	Ice Cream Maiden Sumame) Bailey	Factory
e, Mar	s 1 and 2 sho if Health and itam 27 is ma othar trauma		19a. Informant's Name/Relationship (Sharon A. Clem (S 20a. Method of Disposition	ister)	1753	2 Virgini	and Number or Rura a Ave. Ap	t#A Hag	erstown,	MD 21740
Baltimore,	t. Pages rtment of rtant: If it		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2). Signature of Funeral Service Licer)	Smithsbu	osition (Name of matory or other place rg Cremat 2. Name and Addres	ory June		Smithsbur is Funera	g, Maryland
Ä	permi Depa Impo any ir		23a. Part1. Enter the disease, or com shock, or heart failure. List only	lications that caused the	1414 1	2525 Brad	bury Ave.	Smiths	burg, Mar	yland 21783 Approximate Interval Between
	Priysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	onsequence of):	2000	PULMOWAR	YDIAB	A N	Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	TENS	WAL S				
P.O. Box 6	death certine attending	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of particle in the second of the sec	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	equires that the sen signed by th ould be detache	by	Part II. Other significant conditions of	entributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	\ \\ \\ \/		e to the cause of death? Probably 4 DUnknown
of Vital Records,	The la ate has page 2	e Completed	25. Was case referred to medical						sy prior death	e autopsy findings available to completion of cause of 1? Yes 2 \(\sum \) No
of V	Physician: r this ce tifica ral director, I	To Be	examiner? 1 Tes 2 No	Hospital:	2 ER/Outpatier		4 Nursing Hom	ne 5 ☐ Reside	ence 6 Other (S	Specify)
Division	i or Attending I after death. Diractor: After I in by the funer	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye		M 1 🗆 Y	Yes 2 □ No		ow injury occurred	
Ω	To the Hospital or Attending Physician: whithin 24 hours after deals. To the Funaral Director: After this certific completely filled in by the funeral director,		4 Homicide determined	building, etc. (S	Specify)	Occurred at the tim	ne date and place a	City or Town	n, State)	Rural Route Number,
	To tha Ho within 24 ! To tha Fu completely	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of ex and manner stated	amination and/or in	vestigation, in my op	pinion, death occurre	d at the time, d	ate and place, and of the signed (Mo	due to the cause(s) onth, Day, Year)
	1		30. Name and address of person who of	ompleted cause of death	(Item 23a) (Type,	Print)	W/W/M	OF H	APPREATING	m) MO
:	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's	Signature		~ ~ ~ ~ ~ /	N	WENT 100	is of the
DHM	/IH 17 Rev 1/20	001		More	ORIGINA	L				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** P M June 3. 2005 Julia Ann Padgett 10:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner La Plata Charles County Nursing & Rehab Ctr. Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 27, 1960 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Washington, DC 1 □ M 2 🕱 F 45 Director 578-96-6818 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner invest be notified at 1 ☐ Yes 2 X No Director Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1903 Michael Rd 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Voucher Examiner U.S. Government 12 and Mental Hygie is marked other permit Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked othe any injury or other traumatic event, sonce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Michael Kline Rebecca Thompson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Rebecca Kline - Mother</u> 4806 Pasture View Ct., Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) Peter's Cemetery | 06-07-2005 | Waldorf, MD St. mecal Service Licensee M01391 Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastati Osteo sarcoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfort 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this 27, Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Natural 1 ☐ Yes 2 No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5 2919 MD ring ames 30. Name an ordress of person who convoleted cause of with (Item 23a) (Type, Print) ST James 102 Centennial istrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2005

			For State Registrar	State of I	Marylan			of Health of Death			iene)5	20438
			Decedent's Name (First, Middle,	Last)						Date of Deat			3. Time of Death
п	Physici		Christofili	Balitsari	s Ph	nayer			T ₁	me 1,	2005	Year	11:40P ^M
	/Medic Examin		4a. Facility Name (If not institution,			Ia) CI	4b. City. To	wn, or Location		1110 15	4c. County	of Death	11.401
	LAdiiiii	CI	Manor Care		_		,	nesda					e
	Funeral			. Sex 7.	Age (In yrs.	last birthday)	If Under 1			Date of Birth	Mont		
	Director		124-28-1659	1□M 2 (□F	81	Yrs.	Months (Days Hours	Min.	(Month, Day, arch 6,	Year) 1924		place (State or Foreign atry) Ceece
			Usual Residence of Decedent				L		1 410	ilen o,	1727	Gi	eece
	ylan how		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	Ma-1-s	io	Maryland Montgo	nerv	Be	thesda	1						1 X Yes 2 No
	7 28	rec	10e. Street and Number				10f. Zip C	ode		10	0g. Citizen of W	/hat Cour	ntry?
	h wit	a D	8701 Hempstead	l Avenue				20817			USA		
	deat	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.	Vas Deceder	nt of Hispanic Or Cuban, Mexica	rigin? (Specify	Yes or No-	14. Race		can Indian,
9	after or Ite		1 Never Married 2 Marrie					7		an, etc.)		k, White,	
සු	ours rel', c	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1□Yes 2☐	No Specify	:		Specify:	Wh	Lte
20	within 72 hours after death with the Maryland ene. than "naturel", or Items 23s or 28s-1 show than "naturel" for must be notified at	Completed by	15. Decedent's (Specify only highest	Education			dent's Usual (Occupation	et of working	1	16b. Kind of Bu	siness/In	dustry
2	thin e.	Jple	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT use	retired)	st of working				
7	od wi	Con	12				Home	Maker			Own I	Home	
멀	al Hy al Hy soth	Be (17. Father's Name (First, Middle, La	st)				18. Moth	er's Name (Fi	irst, Middle, M	Maiden Sumame	9)	
<u>a</u>	uld b Menti Irked Itic e	To	Panayotis Bali	tsaris				Pi	oitsa K	Kazangi	ls		
Maryland 21215-0036	s me		19a. Informant's Name/Relationship			19b. Mailin	g Address (S	Street and Numb	er or Rural Ro	oute Number,	City or Town,	State, Zip	Code)
	alth alth 127		Roger Fortier/Br	other-in-	law	8701	Hempst	ead Ave	. Beth	esda, 1	MD 2081	7	
ore	item item		20a. Method of Disposition			lace of Dispo	sition (Name	of er place)	June 4,	2	20c. Location - (City or To	wn, State
E	Page nent contribution of the series		1 ☐ Burial 2 【XCremation 3 3 4 ☐ Donation 5 ☐ Other (Spe		.te	-	-	matory	2005		Alex.,V	irgi	nia
Baltimore,	- 5 2 2		21. Signature of Funeral Service Li	- A	,,,,,,,			Address of Facili	ity Do		neral F		
ő	Depar Impor any ir		Henrys	Frank		2.2	22 Wis	sconsin					C. 20007
			23a. Part1. Enter the disease, or co	omplications that caus	ed the death	. Do not ent	er the mode of	of dying, such as	cardiac or re	spiratory arre	st.	ь р.	Approximate
			shock, or heart failure. List or Immediate Cause (Final	ny one cause on each	1 11110.								Interval Between Onset and Death
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	xecu and al-tra	ха	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of):							
8760,	ficate be executed physician and s the burial-transit	a											
687	phys the	dical		d						-			
	The law requires that the death certifinite has been signed by the attending roage 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcon	ne of pregna	ncv					024 0-4	-4-4-15	
Вох	atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic preg				23d. Date Mon		Day Year
o.	he dr the ched	ysle	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 Unknown		Jail J_	Other (speci	·y)					
<u>α</u>	that I ed by deta	H-	Part II. Other significent condition	contributing to death	but not resu	ulting in the ur	ndertving cau	se given in Part	1.	23e. Did tobi	acco use contri	bute to th	e cause of death?
ds,	es pe	d by		3		3	, , ,	g. 101/ 11/ 14/1					ably 4 □Unknown
0	w requir been si should	etec											
Vital Records,	has by	Completed								24a. Was an autopsy	pr	ior to cor	osy lindings available npletion of cause of
<u></u>		S								perform 1 ☐ Yes 2	100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	eath?	2 No
/itg	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?						e of Death Cl				
	S S	은	1 ☐ Yes 2 XX No	Hospital: 1 ☐ Inpa		ER/Outpatien			ursing Home	5 Resider	nce 6 Othe	r (Specify)
2	ding P h. After 1 funera	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury Da <i>y Year)</i>	28b. Time of Injury	28c	Injury at Work?	28d.	Describe how	w injury occurre	d	
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Division of	or Attendated after death	ŧ۱	3 Suicide 6 Could no 4 Homicide determine	ad 28e. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, lactory, o	ffice	28f.	Location (Streetly or Town,	eet and Numbe State)	r or Rura	Route Number,
	rel D								1				
	e Hospital 24 hours a Funerel letely filled	edical	(Check only 2 Medical Ex	Physician: To the be- aminer: On the basis	st of my know of examinat	wledge, death ion and/or inv	occurred at restigation, in	he time, date an	nd place, and ath occurred a	due to the car	use(s) and man	ner as st	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	one)	andmanner	stated.								
	To To	a=	29b. Signature and title of certifier	Se f			29c. L	icense number		29	d. Date signed	(Month, L	Jay, Year)
			(Alst th	1			DO	055694		J	une 2,	2005	
	10		30. Name and address of person wh										
	, ,		Alok Mathur, M.I					d. Olne	y, MD	20832			
	Sta		31. Date liled (Month, Day, Year) JUN 0 6	2005 32. Pgis	strar's Signat	B A	reste						
	Registra	ar	0011 0 0	COOJ OCA	we s	17							

			For State Registrar	State of Ma	aryland / Dep	artment ertificate					Reg. No.		0	20439
	Physici	an	1. Decedent's Name (First, Middle, Las							Oate of De Month	Day		Year	3. Time of Death
	/Medic	al	Helen Trover Pier			41. 02. 7		LaseKasa	4 On oth	May 3	-	005 County a	f Dooth	1:55 P ^M
	Examin	er	4a. Facility Name (If not institution, give					Location o	t Ceath					-37
			13617 Jamieson P1 5. Social Security Number 6. S		e (In yrs. last birthda		mani 1 Year	If Under a	24 Hrs.	8. Date of Bir (Month, Da		lontg		- y place (State or Foreign ntry)
н	Funeral Director			□M 2∏F	88 Yrs.	Months	Days	Hours	Min.	(Month, Da 09/27	/ 191	6		inois
	ס		Usual Residence of Decedent		40- 0h T									O. I. I. I. I. Charling
	show	-	10a. State 10b. County MD Montgome	~~~	10c. City, Town or Germant									0d. Inside City Limits 1 X Yes 2 No
	88e-f	ecto	MD Montgome	ГУ	German	10f. Zip	Codo				10a Citi	zen of Wi	hat Cour	
	n 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show culcul Exercitivational be notified at	Funeral Director	21000 Father Hurl	ev Bouleva	ard Ant.30						•	S.A		iu y :
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 1	. Was Decede	ent of Hi	spanic Orig	gin? (Spec	cify Yes or No		14. Race	- Americ	can Indian,
ယ	or Iter		1 Never Married 2 Married	Armed Forces?		If Yes, speci			, Puerto R	lican, etc.)			, White,	etc.
21215-0036	ours a	l by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	TĀĪ NO	Specify:				Specify:	Whi	ite
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Gi	edent's Usual ve kind of work DO NOT use	k done c	lurina most	t of workin	g	16b. Ki	nd of Bus	iness/In	dustry
121	within ene. then "	d L	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5	5+)	narian		,			Т 4	brar	37	
D 2	be filed within 72 ho ital Hygiene. Id other then "netur event, IT e Medical		17. Father's Name (First, Middle, Last)	2	المنا	orarian	L	18. Mothe	r's Name	(First, Middle			_	
an		To Be	James Trover					Edn	a Wat	ers				
Maryland	운 전 보 보	-	19a. Informant's Name/Relationship (Турө, Print)	19b. Ma	iling Address	(Street a	and Numbe	r or Rural	Route Numb	er, City o	r Town, S	itate, Zip	Code)
	1 and 2 Health a tem 27 is		John Pierson, Sor	1	136	l7 Jami	Leso	n Pla	ce, (Germant	town,	MD	2087	74
altimore,	ges 1 ar it of Hea if item or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	20b. Place of Dis cemetery, c	position (Nam ematory or ot	e of her plac	e)	Da	ate	20c. Lc	cation - (City or To	own, State
Ē	artment ortent: linjury of injury of	-	`4 □Donation 5 □ Other (Specif	v)	Ft. Line								d, N	Maryland
Ball	Department of H Importent: If ite any injury or ot once.		21. Signature of Fuperal Service Licer	1599	-	22. Name and				nple Ti			1	1 20052
	40260		Janky Tea	olications that cause	7							, Ma	гута	Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each h	ne.	into the mede	or ayını	9, 3001 00	our dido or	roopiiatory a	.,,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ч. ———	n Cancer a consequence of):		<u> </u>							
	Examiner			Due to (or as	a consequence on.									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):									
	cuted nd ransit	Examin	that initiated events	C										
90,	e exe		resulting in death) Last	Due to (or as	a consequence of):								1	
8760,	The law requires that the death certificate be executed the second signed by the attending physician and be a signed by the attending physician and be detached for use as the burial-transit	Physician/Medical	•	d										
9 хо	eath certific attending pl	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date	of delive	90/
Bo	atten for u	clan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B Ectopic pre					'	Mon		Day Year
P.O.	that the de led by the a detached	nysi	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□ Unknown										
	es that igned b	by Pi	Part II. Other significant conditions	ontributing to death b	out not resulting in the	underlying ca	ause give	en in Part I.		23e. Did	tobacco ι	ise contri	bute to ti	he cause of death?
Records,	w require been sig should b									1 🗆	Yes 2	□ No :	3 🗌 Prob	pably 4 Munknown
900	e law re has bei je 2 sho	piet								24a. Was	DSV	24b. W	ere auto	ppsy findings available impletion of cause of
E E		Completed								perfe 1 ☐ Yes	órmed? 2∰ No	de	eath?	2□ No
Vital	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hearital			Oth			(Check only				. Son's
of	Physi this al dir	7	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 ☐ Inpatie				4 🗆 190		ne 5 Res 8d. Describe				Residence
	ding After fune	tion	1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) Injur	M	8c. Injun W <i>o</i> ri 1 □	k? Yes 2□		54. B 55511B5	110 11 11 11 10	, 0000110		
Division	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	jury - At home, farm,	street, factory	, office		2	8f. Location	(Street an	d Numbe	r or Rura	al Route Number,
Ö	al or after	Certification:	4 Homicide	building, et	tc."(Specify)					City or To	wn, State)		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner st	of examination and/or	ath occurred a investigation,	at the tin in my o	ne, date an pinion, dea	d place, a th <i>o</i> ccurre	nd due to the	cause(s) , date and	and mar place, a	ner as s	tated. o the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	^		29c	. Licens	e number			29d. Da	e signed	(Month,	Day, Year)
)			1 /am/l	ℓ				D 4"	761	2	Jui	ne 03	3, 2	005
	10		30. Name and address of person who											
	6		Paul Mackoul, MD	, 8218 Wis	consin Av	e. #414	4, B	ethes	da, l	MD 208	14			
	્ Sta Regist		31. Date filed (Month, Day, Year) 6	2005 32. Project	rar's Signature	Spark								

n	1 - State of Maryland / Department of Health a State of Maryland / Department of Health a 23a,27,28a-f per me C346 8-11-05. Registrar	and Mental Hygi tas	ene g. No.2 (111) 1 2 111, 1, f
Dhysisian	1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Physician /Medical		June	10 2005 7:53 A M
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death	4c. County of Death
2	Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hz. 1	N/A
Funeral Director	220-71-7961 1 M 2 F Yrs. 131 Dilling Pays Hours 15 Hours	Min. 8. Date of Birth (Month, Day, April	9. Birthplace (State or Foreign Country) 26 2005 Maryland
	Usuel Residence of Decedent	API II	20 2005 taryrana
show	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
with the Ma or 288-fs by nutified Director	Maryland Baltimore Baltimore		1 X Yes 2 □ No
ath with the Mar 23a or 28a-f st ust by nutified ral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
leath	242 Colgate Ave. 21222 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	gin2 (Specific Ven as No	USA
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. that than "natural", or Items 23s or 28s-1 show ant, Its Madical Examinant matural and the matter	Armed Forces? If Yes, specify Cuban, Mexican 1 Ves 2 No	Mexican	14. Race - American Indian, Black, White, etc. Specify: Hispanic
72 hours		110	6b. Kind of Business/Industry
21215-00 ed within 72 ho ygiene. nar than "natur. it, the medical.	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) (Elementary/Secondary (0-12) College (1-4or 5+)	t of working	,
nd 2121 e filed withing at Hygiene. other than yant, if a M.	0 Infant		Infant
land left left left left left left left left	17. Father's Name (First, Middle, Last) 18. Mothe	r's Name (First, Middle, Ma	
Aarylan 2 should be 3 and Mental 4 is marked or reumatic eve		a Popoca Cru	
ges 1 and 2 should be filed within 72 hours aft to Health and Mental Hygiene. If itom 27 is marked other than "natural", or or other traumatic event, Its Medical Examing To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) Sandra Popoca Cruz (Mother) 242 Colgate Ave. Ba		
Baltimore, Me permit. Pages 1 and 2 Department of Health a Important: If tian 27 is any injury or other traa ange.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)		Oc. Location - City or Town, State
Balti permit. Departm Imports any inju	21. Signature of Funeral Service Licensee Municipal Cemeterv 22. Name and Address of Facility RIVETA FUNERAL	-17-2005 Pu	eblo, Mexico
a 88 a 8		e. Corona, N	Y. 11368
Physician	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respiratory arres	
/Medical	disease or condition resulting in death) a. Sudden Unexplained Death In Infa Due to (or as a consequence of):	iicy (SUDI)	
Examiner	Sequentially list conditions b		
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		
60, be executed ician and burial-transit	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
buricia			
	d.		
Box eath cer attendir for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown		23d. Date of delivery Month Day Year
P.O. that the do be by the detached	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
cords, w requires been signe should be		1 □ Yes	2 No 3 □ Probably 4 □Unknown
Vital Records, dician: The law requires the certificate has been signed rector, page 2 should be completed by		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No Yes 2 \sum No
f Vita ysician: is certifica director,	25. Was case referred to medical examiner?	of Death (Check only one)	10 10 100
of V Physic this co al dire	Y Yes 2 No Hospital: 1 □ Inpatient 2 ER/Outpatient 3 □ DOA Cther: 4 □ Nur	sing Home 5 Residence	ce 6 □Other (Specify)
Division of tea or attending Physics after death. The after death of the funeral died in by the funeral death of t	27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Mogth. Day Year) Found: Tound: 7:15 28b. Time of Found: Work? 7:15	28d. Describe how	injury occurred unk
in Diriginal	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence	28f. Location (Stree City or Town, S Dundalk	et and Number or Rural Route Number, State) 242 Coleate Avenue Baltimore County, MD
Hosp 24 hou Funel Stely fil	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	I place, and due to the caus	so(s) and mannes as stated
within 2 To the comple	29b. Signature and title of enrifier 29c. License number	29d.	. Date signed (Month, Day, Year)
16	OCME OCME		une 10, 2005
4/2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street	et Baltimore	e, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) JUN 1 4 2005 Registrar's Signature		

Physician /Medical Examiner 4 Funeral Director 1 Management of the profile of t	1. Decedent's Name (First, Middle, Julia Carlos Constitution, School Carlos Car	ive street and number) Sex 1 M 2 XF 7. Age (in y 91	iley al Hosp. rs. last birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	Location of Death	2. Date of Dea Month June	2nd 20	
Funeral 5 Director	5. Social Security Number 220–38–4311 Usual Residence of Decedent 10a. State 10b. County Maryland Howa: 10b. Street and Number	Sex 7. Age (in y 91	rs. last birthday)	If Under 1 Year	w113	pra		
Director	Usual Residence of Decedent 10a. State 10b. County Maryland Howa: 10e. Street and Number	10c.	Yrs.		If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
ems 23a or 28e-f show er nuisi be notified at uneral Director	10a. State 10b. County Maryland Howa: 10e. Street and Number			Monard Bays		March 1	7, 1914	Washington, D
ems 23a or 28e-f sign rules be notified at rules be notified to rules be not the rules of the rules be not t	10e. Street and Number	d	City, Town or Lo	cation				10d. Inside City Limits
ems 23a or 2 er nust be no unerai Dire			Clarks	ville				1 ☐ Yes 2 ☑ No
er must		7.1		10f. Zip Code			10g. Citizen of Wha	t Country?
0 3	11. Marital Status	12. Was Decedent Ever in	u.s. 13. V		029 ispanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	14. Race -	SA American Indian,
el', or it	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		fYes, specify Cuba 1⊡Yes 2 🙀 No	n, Mexican, Puerto Specify:	Rican, etc.)		White, etc. White
	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	DO NOT use retired	during most of worki)	ng	16b. Kind of Busin	,
主 中 三 4 1	17. Father's Name (First, Middle, La	5+ st)	Soc	ial Worke	18. Mother's Name	(First, Middle,		lic Charities
s marked o umatic eve	Francis Dorse	y			Mary	Mooney		
(O - O - O	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a	and Number or Rura	l Route Number	r, City or Town, Sta	te, Zip Code)
item 2	Mary R. Raffert 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 1 □ Donation 5 □ Other (Special Control of Cont	☐Removal from State	cemetery, cren	Westcot sition (Name of natory or other place an Cremator	θ) June	e 3,	20c. Location - Cit	
Department of Importent: If any injury or once.	21. Signature of Funeral Service Lic		22 F	Name and Addres	is of Facility Collins	Funeral	Home In	a, Virginia c. ing, MD 20901
the burial-transit	23a. Part 1. Enter the disease, or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons C. Due to (or as a cons Due to (or as a cons Due to (or as a cons d.	Congequence of): SCHM equence of): ypera	estre o	heart d	respiratory arr	est,	Approximate Interval Between Onset and Death
ed by the attending p detached for use as y Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
n signed by	Part ii. Other significant conditions	contributing to death but not r	esulting in the un	derlying cause give	n in Part I.	23e. Did tot		e to the cause of death? Probably 4 Unknown
						24a. Was a autops perform	ned? prior deat	autopsy findings available to completion of cause of n? res 2 \sumbox No
this cer al direc To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	ne 5 Reside	ence 6 Other (5	Specify)
Dire in b	3 Suicide 6 Could not 4 Homicide determine	building, etc. (Spe	cify)			City or Towr	n, State)	r Rural Route Number,
thin 24 hours the Funer mpletely fill	(Check only 2 Medical Ex	thysician: To the best of my kaminer: On the basis of examinand manner stated.	nation and/or inv	estigation, in my op	inion, death occurre	d at the time, da	ate and place, and	due to the cause(s)
within 24 hours a To the Funerell completely filled Medical Ce	29b. Signature and title of certifier / 29b. Signature and title of certifier / 29b. Signature and address of person who so the signature of t	de My		29c. License	number 70 870	2:	9d. Date signed (M	onth, Day, Year)
8 3	30. Name and address of person who 5005 SignMu	completed cause of death (It	em 23a) (Type, F	Print) usull	LMD	21020	1/ Suz	an Abdo M

			1 - For State of Ma	aryland / Depa	artment of H		nd Me		ene) 5	20442
			Decedent's Name (First, Middle, Last)				2.	. Date of Death	1		3. Time of Death
	Physici /Medic		Irving Reynolds					Month 06 - 04	Day 4- 200	Yeer 5	6:48 a M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Localion of			T	y of Deeth	
			Holy Cross Hospital		Silver				Mon	tgome	
	Funeral		₩ ans	(In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,			place (State or Foreign ntry)
	Director		579-54-0927 Usual Residence of Decedent	63 Yrs.			0	3-14-19	942	Wash	ington, D.C
	yland pow		10a. Slate 10b. County	10c. City, Town or Lo	cation						10d. Inside City Limits
	a-f st	tor	Maryland P.G.	Bre	ntwood						1 XYes 2 No
	or 28	Oire	10e. Street and Number		10f. Zip Code			10	g. Citizen of	What Cou	ntry?
	ath w	rail	4305 34th Street		20	0722			U.	S.A.	
	er de	Funeral Director	11. Marital Status 12. Was Decedent I Armed Forces?	l l	Was Decedent of H f Yes, specify Cuba	lispanic Origii an, Mexican, I	in? (Specif Puerto Ric	y Yes or No- an, etc.)		ce - Ameri ick, White,	can Indian, , elc.
36	irs aft	by F	1 ☐ Yes 2 ☐ Married 1 ☐ Yes 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10	I□Yes 🛣 No	Specify:			Specia	y: Bla	ick
ğ	within 72 hours after death with the Maryland ene. then "neturel", or terms 23e or 28e-f show the Medical Exempter must be notified at	ted	15. Decedent's Education	16a. Deced	lent's Usual Occup	pation		1	6b. Kind of E	Business/In	Idustry
215	thin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life. L	kind of work done OO NOT use retired	<i>d</i> u <i>ring</i> most o d)	of working				,
2	ed wi	Completed	9th	Labo	rer			ŀ	lo1mes	Cont	ruction
pu	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last) Francis Reynolds					First, Middle, M ardson	laiden Sumar	m <i>e)</i>	
yla	1 Mer narke	To				L.,					
Mai	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship (Type, Print) Susie Owens / Sister	4305	Address (Street 34th Stre	and Number	or Rural R	loute Number,	City or Town	, State, Zip) Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Evertives must be notified at 2008.		20a. Method of Disposition	20b. Place of Dispos cemetery, crem	wood, Man		, ZU/ Date		Oc. Location	- City or To	own. State
OL.	ages ent of nt: If i		1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	Chesapeal			6 07				, Maryland
票	mit. F partm oorter injur		21. Signature of Funeral Service Licensee		. Name and Addre						
m	Depar Depar Impo		Wanda C, Bacon C	036/ 34	447 14th	St., N	V.W.	Wash.,	D.C.	20010	
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dyin	ng, such as ca	ardiac or re	espiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Pneumon	ia							Onset and Death
	/Medical Examiner		resulting in deal(1)	consequence of):							
		7	Sequentially list conditions,	consequence of):							
	nted Insit	min	cause. Enter Underlying Cause (Disease or injury	oursequence or,							
o,	execting and ial-tra	Examiner	trial initiated events	consequence of);						_	
8760,	icate be executed physician and s the burial-transit	dicai	d								
9	ing ph	0	IF FEMALE:								
Вох	attending p	lan/	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	,				te of delive	ery Day Year
P. O.	at the de by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death 5	Other (specify)				1	,,,,,,	Day Teal
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death but	t not resulting in the un	ideriving cause give	en in Part I.	1	23e. Did toba	icco use con	tribute to th	he cause of death?
Vital Records,	uires sign lid be	d by	Anoxic Encephalopathy	•				1 ☐ Yes	2 🔀 No	3 Prob	pably 4 Unknown
OS	w require s been sign should b	Completed	Seizure Disorder				_	24a. Was an	24h.	Were auto	psy findings available
Re	The lay	omp						autopsy perform		prior to coi death?	mpletion of cause of
ta	sicien: Th certificete irector, pag	BeC	S/P . Tracheostomy 25. Was case referred to medical			26. Place of	f Death (C	1 ☐ Yes 2X		1 🗌 Yes	2 L NO
>	nysic nis ce direc	ToE	examiner? 1 Yes 2 No Hospital: 1 Ninpatier	nt 2 ER/Outpatient	3 □ DOA Oth	00		5 Residen		er (Specif	(y)
Division of	ding Ph h. After thi funeral		27. Manner of Death 1 XNatural 5 ☐ Pending (Month, Day)	Year) 28b. Time of Injury	28c. Injun Wor	y at k?	28d	. Describe how	injury occur	red	
Sio	tendi death. tor: A the fu	cati	2 Accident investigation			Yes 2 □ No					
\leq	or All after of Direction by	Certification;	4 Homicide determined 28e. Place of Injubuilding, elc	ry - At home, farm, s)re (Specify)	el, factory, office		281.	City or Town,		er or Rura	al Route Number,
	spitel cours nerel filled		29a. Certifier 1 Certifying Physicien: To the best o	f my knowledge death	occurred at the tim	ne date and r	place and	due to the cau	se(s) and ma	annar as el	tated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or inv	estigation, in my of	pinion, death	occurred a	at the time, dat	e and place,	and due to	the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	1110	29c. License		_		d. Date signe		
	10		> Krawa hang			5087			une 6,	200.	5
0			30. Name and address of person who completed cause of de	ath (Item 23a) (Type, F					000	10	
			Kshama Garg, MD 31. Date filed (Month, Day, Year) 22. Registra.	's Signature		Sprin	ng, Ma	aryland	, 209.	LU	
	Stat Registra	_	JUN 0 7 2005 Keepen	A Spen	the same						

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of		nd / Depa		Health and N	/lental Hyo		2005	201.1.3
			Decedent's Name (First, Middle	, Last)				20417	2. Date of Dea			3. Time of Death
ı	Physic		Edward Rodge						June	2, Day	2005	
	/Medi Examir		4a. Facility Name (If not institution		er)		4b. City. Town. o	or Location of Death		_	ounty of Death	2:00 P.M
1	Exami	iei	12313 St. Albar		,			shington			ince Geo	rao! a
	Funeral				Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti			
	Director		056-12-4882	6. Sex. 7. 1 ☐ M 2 ☐ F	87	Yrs.	Months Days	Hours Min.	8. Date of Birti (Month, Day 9/3/17	(, Year)	Coun	lace (State or Foreign try) n,S.C.
	ס		Usual Residence of Decedent								Olite	11,0.0.
	nyian how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				11	0d. Inside City Limits
	e Ma	cto	Md. P.G.			Fort	: Washing	rton				1 ≹ Yes 2 ☐ No
	th th or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Coun	try?
	23a	<u>a</u>	12313 St. Alb	an Circle			20	744		U.	S.A.	
	r deg	ne	11. Marital Status	12. Was Decede Amed Force	ent Ever in U	I.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		. Race - America	
36	or It	下 元	1 Never Married 2 Marri	ed 1 Yes 2	□ № 43-		1 □ Yes 2 No					ack
21215-0036	within 72 hours after death with the Maryland ene. than "neturet", or Items 23e or 28a-f show te Madical Examiner, and by notified at	d by	3 ∰Widowed 4 □ Divorced	Year or Date	es:							
5	"net	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Deced	dent's Usual Occup kind of work done	oation during most of work d)	ring		of Business/Inc	
12	withir ane. than	를	Elementary/Secondary (0-12) 5th	College (1-4	or 5+)		er Engine			_	er Reed	
d 2	filed Hygid ther	ပ္သ	17. Father's Name (First, Middle, I	_ast)		DOTTE	i mgine	18. Mother's Nam	e (First Middle	Maiden Si	(mame)	
aŭ	d be	Be C	Eddie Rodgers						Robinson		imame)	
2	hout d Me mark matie	ို	19a. Informant's Name/Relationsh	in (Type Print)		10b Mailir	an Address /Street	and Number or Rur			Town Chair 7's	0-4-1
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other treumatic event, it a Marical Examination at the multifled at ONCE.		Lillie R. Willi		or							
	1 an Heal Heal		20a. Method of Disposition	alis/ Daugitt		Place of Dispo	sition (Name of	ban Cir.,			on IMO . tion - City or To	
Baltimore,	ages nt of t: If it		1 Burial 2 ☐ Cremation		ate Fi	emetery, crer T.i.n.c	sition (Name of natory or other place coln Cem.	6/10			wood, M	
퍮	it. Purtine		`4 □Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		+ '							u.
Ba	Dermi Depa Impo any ii		21. Signature of Fulleral Service L	IN DAD	77	22	H.S.Wash	ss of Facility nington &	Sons Co	.,Inc	·	
		1	23a Part 1 Enter the disease or	complications that cau	sod the deal	49	925 Burro	oughs Ave.	$-N_{\bullet}E_{\bullet}$	Washi	ngton,D	.C. 20019 Approximate
			23a. Part1. Enter the disease, or shock, or heart failure. List of					ig, such as cardiac	or respiratory arr	est,		Interval Between Onset and Death
	Physician /Medical	6	Immediate Cause (Final disease or condition resulting in death)	-		- FA	lure					
н	Examiner			Due to (or	as a conseq	juence of):	F Pros					
Н		<u>~</u>	Sequentially list conditions,	b. Due to lor	SUCCI	uence off:	t ro.	tate				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		us u comoco	Profession of the						
	xecu and	xar	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):						
1760,	icate be executed physician and s the burial-transit	calE										
587				d								+
.O. Box 68	The law requires that the death certifica Ite has been signed by the attending ph tage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregna	ancy				220	I. Date of deliver	
ğ	atter atter	clar	in the past 12 months?	1 ☐ Live birth	2 Feta	I death 3	Ectopic pregnancy Other (specify)	•		230		Day Year
o.	the d y the	ıysı	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknowr								
ם.	that ned b	Ā	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol	oacco use	contribute to the	e cause of death?
sp.	uires sigr	d by							1 □ Ye	s 2	No 3 ☐ Proba	bly 4 Unknown
õ	w require been si should I	lete							24a. Was a	, ,	Ah Wara sutan	sy findings available
Re	he la e has ge 2	Completed							autops	v	prior to com death?	pletion of cause of
Division of Vital Records,	hysician: The law nis certificate has I I director, page 2 s		25. Was case referred to medical						1□ Yes 2	2 Kg No	1 Yes	2 🗆 No
5	Physician: r this certifica ral director, p	o Be	examiner?	Hospital:		5D(0	Oth	er:	111			
ō	Phys r this ral di	2	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inpa		ER/Outpatien 28b. Time of	1 3LI DOA	4 Nursing Ho	me 5 eside 28d. Describe ho			
o	Attending r death. ector: After by the funer	햩	12 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month,	Day Year)	Injury	Wor	k?¨ Yes 2 □No	200, 2000, 100 110	,, u., u.,	00011.00	
ISI	dea dea ctor y the	flca	3 ☐ Suicide 6 ☐ Could n	ot be	Injury - At he	ome, farm, stre	eet, factory, office	_	28f. Location (St	reet and N	lumber or Rural	Route Number
ă	2 2 2 2	Certification:	4 Homicide determin	building,	etc. (Specif	y)	,		City or Town	, State)		,
	Hospitel 24 hours a Funeral I tely filled	aC	29a. Certifier 1 Certifying	Physician: To the be	est of my kno	wledge, death	occurred at the tir	ne, date and place.	and due to the ca	ause(s) an	d manner as sta	ted.
	e Ho 124 h	edical	(Check only 2 Madical E	xaminer: On the basis and manner	s of examina	tion and/or inv	estigation, in my o	pinion, death occurr	ed at the time, d	ate and pla	ace, and due to	the cause(s)
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Me	29b. Signature and title of certifier	11			29c. Licens	e number	2	9d. Date s	igned (Month, D	ay, Year)
				w			00	11182		6/	3/0	5
	(0111		30. Name and address of person w	ho completed cause of	of death (Iten	1 23a) (Type. I				- /		
-1	6/189		Felton Ander	·			,	Suite 350	Ft. Was	hinat	con "Md 3	20744
	Sta	te	31. Date filed (Month, Day, Year)	2. Regi	strar's Signa	ture	-		, _ , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		prikle 2	40 / TT
	Registr	ar	JUN 0 7 20	05 Bleen	J JK	Space	les .					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Maryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			giene Reg. No.	J 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	24
	Physici /Medic		1. Decedent's Name (First, Middle	stin Stever	ns			2. Date of Dea Month June	ath Day	Year 005	3. Time of Death
	Examir		4a. Facility Name (If not institution	-		4b. City, Town, or	Location of Death	0 42.0	4c. County		J.1J F.
			Prince George 5. Social Security Number		Center Age (In yrs. last birthday)	Chever	lf Under 24 Hrs.	Done of Riv	Prince		
	Funeral Director		578–38–7423 Usual Residence of Decedent	1 M 2 XF	75 Yrs.	Months Days	Hours Min.	8. Date of Birt. (Month, Da) 4/3/3(Y. Year)	Cour	lace (State or Foreign htry) arolina
	/land		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	a-f et	ctor	Md. P.G.		Lanhan	ì					¥⊟Yes 2□No
	or 28	Director	10e. Street and Number	77 // 000		10f. Zip Code			10g. Citizen of		itry?
	eath v	erai	6882 Riverdale	12. Was Decede	at Everin II S 12	207			U.S.A		an India
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Ifem 27 Is marked other than "neturel", or Items 23e or 28e-f ehow other traumatic event, The Medical Examinar must be multified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	Armed Force	s? ⊋No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto	ecity Yes of No- Rican, etc.)	Specifi		
2-0	72 hc	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dece (Give	dent's Usual Occupa	ation Juring most of worki	ina	16b. Kind of B		dustry
121	within ene. than "	ldm	Elementary/Secondary (0-12)	College (1-4d		kind of work done d DO NOT use retired, Se's Assis			Nursin	-	
d 2	filed Hygid Sther ent, II		17. Father's Name (First, Middle, I	Last)	IVOLE	C 2 V22T2	18. Mother's Name	e (First, Middle,	D.C. Vi		3
<u>la</u> n	should be nd Mental marked c	To Be	David Austi	n, Jr.			Mary A	Algora			
Maryland	2 should be filed w and Mental Hygie Is marked other ti raumatic event, II.	'	19a. Informant's Name/Relationsh			ng Address (Street a				State, Zip	Code)
	1 and Health em 27 ither to		Marian N. Austi 20a. Method of Disposition	n/Daughter	6882 20b. Place of Dispo	Riverdale	The second secon	2, Lanha		2070	
mor	0 0		Burial 2 Cremation 4 Donation 5 Other (Sp		te cemetery, crei	matory or other place Mem. Park	9)		Landove	-	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service I	-	att H	Name and Addres S.Washin 925 Burro	s of Facility gton & So	ons Co.,	Inc.		
	1.0		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the death. Do not ent	er the mode of dying	, such as cardiac o	or respiratory arr	rest,	JOIL D	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		plu	Sho	r.B.	0			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):		11/11/1	// .			
	4 8	er	Sequentially list conditions,	b. Justo (or	MOMES a consequence of	opene	eux	3	4.		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1/192	man	and	en L	Lase	do	e	
0	sician and burial-transit		resulting in death) Last	Due to (or	a consequence o	1					
68760,	the the	edical		d	nam	us					
	certific ding p	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregnancy				22d Day	to of dollars	
O. Box	at the death certi by the attending tached for use a	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			Mo	te of delive nth	Day Year
S, D	requires that the reen signed by th hould be detache	by Ph	Part II. Other significant condition	contributing to death	but not resulting in the un	nderlying cause give	n in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
S C	w require been sig should b		Rongel	Fan	eurs.	1		1 🗆 Y	es 20 No	3 🗆 Proba	ably 4 □Unknown
Vital Record	> 0	Completed	Verlmo	nan	H mas	lone	sion	24a. Was a	sy p	prior to con	osy findings available
E E	icien: The lav certificate has ector, page 2		acute 12	espera	to Du	shess.	Symbol	perfor		death?	2□ No
<u> </u>		o Be	25. Was case referred to medical examiner? 1 \(\subseteq Yes \) 2 No	Hospital:	itient 2 ☐ ER/Outpatien	Othe	26. Place of Death				
		<u> -</u>	27. Manner of Death	28a. Cate of Ir	njury 28b. Time of	t 3 DOA 28c. Injury Work	4 INUISING HO	ne 5∟ Reside 28d. Describe h)
joi	endin sath. or: Aft he fur	atio	Natural 5 Pending investig	ation	Day Year) Injury		es 2□No				
Division	Hospitel or Attending P 24 hours after death. Funerel Director: After tiely filled in by the funera	Certification	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	2	281. Location (Si City or Town		er or Rural	Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be- xaminer: On the basis and manner	st of my knowledge, death of examination and/or inv stated.	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the cased at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)
	To the within to the complex c	Σ	29b. Signature and title of certifier	1		29c. License		2	9d. Date signed	Month	Day, Year)
			1/100	toves			303/	5	6/1	10	5
U	2		30. Name and address of person v		f death (Item 23a) (Type, 300) .HosPi	A -	6	HEVERLY	MD	2018	35
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 20		strar's Signature				/		

			For 1 = State Registrar	State of N	Maryland		artment of F		and Mer		ene	15	201.1.5
			Decedent's Name (First, Middle	, Last)					2.	Date of Death		- No.	3. Time of Death
	Physicia		Norman	Arlie		Ch.	rout, Sr.			Month	Day 2005	Year	8:55 P M
	/Medic Examin		4a. Facility Name (If not institution,		or)	511.	4b. City, Town, o			une l	4c. County		
П	LAdiiiii	eı	Garrett County	•		1		kland			,		rett
	Funeral		5. Social Security Number		Age (In yrs. Ia:		If Under 1 Year	If Under 2	24 Hrs. g.	Date of Birth			place (State or Foreign ntry)
	Director		217-14-4400	1໘M 2□F	83	Yrs.	Months Days	Hours	Min. (Month, Day, 1	Year)		ntry) rvland
			Usual Residence of Decedent					1	ria	1.0,	13,44	ria	ГАТОПО
	yian how		10a. State 10b. County	_	10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mar.	ģ	MD	Garrett			0ak1	and					1 ☐ Yes 2√☐ No
	r 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of W	hat Cou	ntry?
	h wit	<u>a</u>	293 Tannery Ro	ad			2	1550			I	JSA	
	deat	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	. 13.	Was Decedent of H f Yes, specify Cuba		gin? (Specify	Yes or No-	14. Race	- Ameri	can Indian,
9	after or ite		1 Never Married 2 Marri	ed 1⊠Yes 2[-		, Puerto Aica	in, etc.)		k, White,	
5-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examinet must be notified at	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	: WW I]		1 ☐ Yes 2 ☑ No	<i>Specify:</i>			Specify:	W.	hite
2	72 hc	Completed	15. Decedent (Specify only highes			16a. Dece	dent's Usual Occup	ation	of working	10	6b. Kind of Bu	siness/In	dustry
7	Mer.	ם	Elementary/Secondary (0-12)	College (1-4o	or 5+)	life.	DO NOT use retired	1)	o, working				
	filed within Hygiene. Ither than "	Con	7th				Stone M	ason			Const	ruc	tion
Maryland 2		Be	17. Father's Name (First, Middle, L					18. Mother	r's Name <i>(Fii</i>	rst, Middle, Ma	aiden Sumame	9)	
<u>8</u>	should to the market umatic e	ဥ	Arlie	Granvill	e	Shr	out	Ethe	el		-	Tus	ing
a	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic ev		19a. Informant's Name/Relationsh	ip (Type, Print)	1	19b. Mailir	ng Address (Street	and Number	r or Rural Ro	ute Number,	City or Town, S	State, Zip	Code)
	and and n 27		Mark R. Shrout/	Son		293	Tannery	Road.	Oakla	nd. Md	. 21550	1	
Baltimore,	ges 1 t of He If iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval from Stat	1	ce of Dispo	sition (Name of natory or other plac		Date		Oc. Location - (own, State
Ĕ		- Transition	1 M Bunal 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp		1	land	Cemetery	4	1/15/20	205	Oaklan	d N	aryland
를	permit. Pag Depurtment Important: any njury o		21. Signature of Funeral Service L	icensee	, ,		. Name and Addres				S. Sec		
ñ	Dep.		Beres les X	in D			Stewart F	uneral	1 Home				yland 21550
ī			23a. Part1. Enter the disease, or	complications that caus	ed the death.								Approximate Interval Between
Ц	Pnysician		shock, or heart failure. List of immediate Cause (Final	only one cause on each	s a D a la	0			0:-	2	1		Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	as conseque	nce of):	ascul	wo	xus e	all		16	years
	Examiner			A A	10.01	es L	II-						110000
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a sunseque	nca of).	7700						grais
	uted insit	듵	cause. Enter Underlying Cause (Disease or injury	es	unhis	10 111	A						142011
	al-tra	Examin	that initiated events resulting in death) Last	C. Due to (or a	as a conseque	nce of):							gears
3/60	cate be executed obligation and the burial-transit	cai		a he	1000	ten	i mi						wars
89	ficate physis the	_		0.	Jaco								7
XON	death certific e attending p id for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date	of delive	Brv
ň	atte	cial	in the past 12 months?		2 Fetel d at time of dea]Ectopic pregnancy] Other (specify)				Mon		Day Year
o.	y th	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
J	g g g		Part II. Other significant condition	ns contributing to death	but not result	ing in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use contri	bute to ti	he cause of death?
g	uires n sign ld be	P	atrial fibr	Hation.	conge	XAV	E beaut,	faile	ve	Yes	2 🗆 No	3 🗆 Prot	ably 4 Unknown
	w requir been si should	lete	chronic 4	2440 4	2-9				11	24a. Wasan	24h W	lere auto	psy findings available
Vital Records,	he fav	Completed by	Cittorice /	enac j	x v	ue.				autopsy	pr		mpletion of cause of
_ 	(0 14									1 □ Yes 2	No 1	☐Yes	20 No
=	sician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Oth	-		eck only one)			
ō	Phys this al di	. To	1 Yes 2 No	1 Ninpa 28a. Date of In	1	R/Outpatien 8b. Time of	I 3 DOA	4 🔲 Nur			ce 6 Othe		(y)
	ding f n. After funer	o u	1 Natural 5 ☐ Pending	(Month, E		Injury	Worl	k? Yes 2 □ N		Describe now	injury occurre	,u	
<u> </u>	death. ctor: A y the fu	ica	2 Accident investig 3 Suicide 6 Could n	ot be	niun - At hom	o form etc	eet, factory, office			ocation (Stra	et and Numbe	r or Dum	I Route Number,
DIVISION	after death after death I Director: d in by the	Certification:	4 ☐ Homicide determi	building,	etc. (Specify)	ie, iaimi, su	set, factory, office		201.1	City or Town,	State)	i oi nuia	I Houle (Valido),
_	Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the fune		200 Contitue	Physician Tathaha	at of our leasure				4 -1 4	d			
	To the Hospital or Al within 24 hours after or Vothe Funeral Directompletely filled in by	edical	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best exeminer: On the basis and manner	of examinatio	n and/or in	estigation, in my o	pinion, death	h occurred at	t the time, date	e and place, ar	nd due to	the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	J.		29c. License	e number		290	f. Date signed	(Month	Dav. Year)
	F % F 8		M	+ 1 L	/ -		1		50		-		
ħ	. (6)		Margane	147	an	M		266	10	6	7-15	eco	U う
1	441K		30. Name and address of berson v	rho completed cause of	r death (Item 2	(Type,	Print)		O. l.	Paul	13- 112	12-1	3
			31. Date iled (Month, Day, Year)	ierma 32 Banis	strar's Signalu	fure	myruna	4	our	and,	VIU L	100	0
	Sta Registra	_	JUN 1 4	2005	· Signatur	le A							
	_			AL AND ENG	TOME O M.	pri 17 16	THE STATE OF THE S						

05-3883 B.K.S CONNIE F. SISK

NIE F. SISK	amend item/4a, perME, G845, 7/8/05 TT State of Maryland / Department of Health and Measure of State of Maryland / Department of Health and Measure of State of Maryland / Department of Health and Measure of State of Death	ental Hygi	ene	5 0011
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) Connie F. Sisk 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Death Month JUNE 6	Day Year	3. Time of Death 2 2249 PM
Funeral Director	212-74-0799	8. Date of Birth (Month, Day, April 4,	FREDERIC Year) 9. Birth Col 1954 Mar	K pplace (State or Foreign intry) yland
the Maryland 28a-f show redifficulal	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick 10e. Street and Number 10f Zin Code			10d. Inside City Limits 1 Ma Yes 2 □ No
er death with Items 23e or Intrinist be Uneral Di		U ₁	g. Citizen of What Counited Stat 14. Race - Amer Black, White Specify: Wh:	es ican Indian, , etc.
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filled within 72 hours att Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other then "naturel", or my injury or other treumstic event, the Medical Exami- BIGS. To Be Completed by F.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) Secretary 18. Mother's Name	C	6b. Kind of Business/li	,
Maryland d 2 should be fill th and Mental H it is marked out treumatic even	Robert Darnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	King Route Number,	City or Town, State, Zi	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 27 it item 27 eny injury or other tre ones.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Frederick Crematory 6/11/	2005 Fr	c. Location - City or T cederick, N	own, State Iaryland
Parmil parmil Depar Impor eny in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Star 1621 Opossumtown Pik 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	ke, Frede	erick,Mary	e, P.A. land 21702 Approximate Interval Between
cate be executed physician and the burial-transit dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
ds, P.O. Box 6i ires that the death cartific signed by the attending p d be detached for use as: 1 by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ❤️Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
cords, P w requires that been signed to should be dett	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	cco use contribute to t	7
f Vital Records, ysiclan: The law requires th is certificate has been signe director, page 2 should be d To Be Completed by	25. Was case referred to medical axaminer? 26. Place of Death (24a. Was an autopsy performe 1 XYes 2 C	d? prior to co	psy findings available mpletion of cause of 2 No
or Attending Physica death. Virector: After this in by the funeral director. After this in by the funeral director.	27. Manner of Death 1 Natural 2 Accident 3 Xsuicide 4 Homicide 28a. Date of Injury 6—600 Say Year) 1 Yes 28b. Time of 28c. Injury at Work? 1 Yes 4 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28b. Time of 28c. Injury at Work? 5 Yound 28b. Time of 10 Yes 4 Nork? 5 Yound 28c. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 5 Yound 28c. Place of Injury - At home, farm, street, factory, office	abject in	ngested dry	IIR al Route Number,
Divisi To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number OCME	d due to the caus d at the time, date	20/0) and manner as a	tated. the cause(s) Day, Year)
State Registrar	30. Name and address of person who completed cause of bath (Item 23a) (Type, Print) THE WORK M. K. J.G. 31. Date filed (Month, Day, Year) 32. Reference Signature	Baltimore	e, Maryland	1 21201

		•	1 - For State amended #4	State of Maryla per FH; FCHI	nd / Depa	artment of Hertificate of L	ealth and Death ⁰⁶	110/000	giene) (05	204	7
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Yeer	3. Time of I	Death
	Physici /Medic		Mamie B.	Sm	allwood			June		2005	8:00	\mathbf{P}_{M}
	Examin	er	4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or		ath	4c. County			
			1411 Key Parkway 5. Social Security Number 6. Sex	7 Ago (In use	. last birthday)	Fred If Under 1 Year	erick If Under 24 H	rs □ Data of Bi⇒h		deri		Faraire
	Funeral Director			м 2 p F 74	V	Months Days	Hours Mi		Year) . 1930	Coun	ace (State or ry) Land	roreign
			Usual Residence of Decedent					June 25	,1550	1141)	Tana	
	arylan show	_	10a. State 10b. County		ity, Town or Lo	cation				10	d. Inside City	
	8a-f	Director	Maryland Freder	ick	Freder						1 ✓ Yes	2 NO
	with t		10e. Street and Number 1411 Key Parkway	7 / Apt. C -	- /1	10f. Zîp Code 21702		1	10g.Citizen of V Unite		_{iry?} :ates	
	ns 23	Funeral		2. Was Decedent Ever in				(Specify Yes or No-		e - Americ		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event, I'm Medical Exami, at most be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 🛍 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, specify Cubar 1 ☐ Yes 2 🕱 No	Specify:	èrto Rican, etc.)		Blac		
Maryland 21215-0036	2 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	tion		16b. Kind of Bu			
215	filed within 72 Hygiene. other than *nal ant, the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	uring most of w	vorking				
2	filed wil Hygien other th	Co	9		Н	omemaker			own h			
ng L	be fill ntal Hy nd oth	Be	17. Father's Name (First, Middle, Last) 011ie	Nove	1			ame (First, Middle,		_		
2	should be Ind Mental I	은	19a. Informant's Name/Relationship (Typ	Nay:		a Address (Street a	Mary		Ambus		Code	
<u>ā</u> ≥	d 2 sho th and 7 is mu traum		Trejetta Smallwood			-		Rural Route Numbel r./AptH/	•			1
စ်	Health tam 27 tam 27		20a. Method of Disposition		Place of Dispo	sition (Name of			20c. Location -			<u> </u>
Ë	Pages nent of int; ff it iry or o		f Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place Cemetery	1	07/2005	Frederi	ck Ma	rvland	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License					tauffer F				
m —	Depa Impo any is		Roymond &	elesson				Pike/ Fre			21702	
3			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	ath. Do not ent	er the mode of dying	, such as cardi	iac or respiratory arr	rest,		Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	Lune	, Ca	near					Onset and D	12
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
		io io	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):					-		-
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause of instance or injury that initiated events	,	, , , , , , , , , , , , , , , , , , , ,							
o`	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
8760	cate be executed physician and the burial-transit	dlcal	d.									
9	ing ph	Med	IF FEMALE:								*-*	-
Вох	death certifi e attending od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregr 1 Live birth 2 Fer	tal death 3	Ectopic pregnancy			23d. Dat Mor	e of delive nth	,	ear
0	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)						
<u>a</u>	The law requires that the de ite has been signed by the a page 2 should be detached to	/Ph	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contr	ribute to th	e cause of de	ath?
Records,	uires sign ld be	d by			-			1 2 Y	es 2□No	3 🗀 Proba	ably 4 🗀 Ui	nknown
o o	w require s been si should b	lete						24a. Was a	an 24b. V	Vere autor	sy findings a	variable
	The fav	Completed						autops	med2	leath?	npletion of ca 2☑No	use of
Vita		Be C	25. Was case referred to medical				26. Place of D	eath (Check only or		<u></u>		
o to	ysic is c dire	To	examiner? 1 Yes 2 40 Ho	ospital: 1 🗌 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	r: 4 🗆 Nursing	Home 5 Neside	ence 6 🗀 Othe	er (Specify)	
Division c	inding Ph ath, r: After th	Certification:	27. Manne Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ′es 2 ⊡No	28d. Describe he	ow injury occurr	ed		
<u> </u>	r Atte	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Si City or Town		er or Rura	Route Numb	er,
	urs af urs af ural D											
	To the Hospital or Attending within 24 hours after death, To the Funaral Diractor: Atter completely filled in by the funer	edical	one)	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death	n occurred at the tim vestigation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time, d	ause(s) and ma late and place, a	nner as stand due to	ated. the cause(s)	
	To I To I	Σ	29b. Signature and title of centifier			29c. License			29d. Date signed	i (Month, l	Day, Year)	
-	~						> 62		6	3-0	7	
	U			npleted cause of death (Ite	am 23a) (Type,	Print) Josep	hAsund	eibn Sen'c	W 1	md.	(15)	50
	Sta Registi	_	31 Date filed (Month, Day, Year)	32. Refristrar's Sign	nature	foots						

		•	1 - For Stata Registrar	State of N	Maryland / E		rtment of I			Re	g. No. 4	05	20448
	Physicia	an	Decedent's Name (First, Middle, Last)					-	Date of Death Month	_	70 gr 0 5	3. Time of Death 6:00A M
	/Medic	al	Helen D. Sparks 4a. Facility Name (If not institution, give	etreet and number	ar)		4b. City, Town, o	or Location o		ne	4 20 4c. County o		0:00A ···
	Examin	er	208 Paradise Road		,,		Aberde				Harfor		
	Funeral		5. Social Security Number 6. Se	x 7.	Age (In yrs. last bin		If Under 1 Year Months Days	If Under Hours	Min	Date of Birth (Month, Day,	Year)		ace (State or Foreign
	Director		220-20-0348 Usual Residence of Decedent] м Ж Д F	78	Yrs.			Mo	y 7,19	27		MD
	fand ow		10a. State 10b. County		10c. City, Town	n or Loc	cation					10	Od. Inside City Limits
	with the Maryland o or 28e-f ahow	ctor	MD Harbord		Aberdee	2n							1 🗆 Yes 2 🗘 No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wi	hat Count	try?
	sath w	eral	208 Paradise Roa	d 12. Was Decede	nt Ever in U.S.	13 V	21001	lispanic Ori	igin? (Specif	v Yes or No-	USA 14. Race	- America	an Indian,
'	fter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2	\$7		Vas Decedent of I Yes, specify Cub			an, etc.)		, White, e	etc.
036	ral', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date	s:	'	☐ Yes 2【X No	Specify:			Specify:	wni	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Items 23a or 28e-f ahow ont, the Medical Examinat must be confilled at	Completed	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a.	Give I	ent's Usual Occu kind of work done OO NOT use retire	oation during mos	st of working	1	6b. Kind of Bus	iness/Ind	lustry
121	filed withir Hygiene. sther than ant, the W	ошо	Elementary/Secondary (0-12)	College (1-4	or 5+)		utive Se				Bankin	ıg	
Ď.	other vent,	Be C	17. Father's Name (First, Middle, Last)		· ·						faiden Sumame)	
Maryland	s 1 and 2 should be filed within 72 hours after death w if Haulth and Mental Hygiene. item 27 is marked other than "netural", or Items 23a othar treumatic event, the Medical Examinat must t	ToE	Benjamin Dorczak						ie Kogr				
Jar	12 sho		19a. Informant's Name/Relationship (7				g Address (Stree Tadise 1						Code)
	1 and 2 Health tem 27		Michael Sparks/son 20a. Method of Disposition				sition (Name of natory or other pla		Date 16-06-		20c. Location - 0		wn, State
ρ	ages ent of nt: If it		1 Burial 2 X Cremation 3 1 4 Donation 5 Other (Specify				d Funero		16-06-1 ne, P.,	2005 A.	Risino	Sun	, MD
Baltimore,	permit. Pages 1 a Department of Hes Imporatent: If item any injury or otha once.		21. Signal of Ineral Service Licen		-		Name and Addr	ess of Facili	ity R.T.	Foard	Funeral	Hon	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that cau	sed the death. Do h line.	not ente	er the mode of dy	ng, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	arcin	0 77	19	-li	79			- (4 WKS
4	/Medical Examiner		resulting in death)	Due to (or	as a consequence	of):							
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence	of):							
	ate be executed thysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
ó,	e exec ian ar urial-ti	Ex	resulting in death) Last	Due to (or	as a consequence	of):							
68760,	tificate b ng physic as the b	dical		d								-	
Box 6	death certificate be executed e attending physician and nd for use as the burial-transit	√/Me	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			- · ·				23d. Date	of delive	ory
	n requires that the death been signed by the atter should be detached for t	by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 □ Fetal death nt at time of death n		Ectopic pregnand Other (specify)	-y 			Mon	th	Day Year
P.0	requires that the leen signed by th hould be detache	Phy	Part II. Other significant conditions of	ontributing to deal	th but not resulting i	in the u	nderlying cause g	ven in Part	1.	23e. Did tob	acco use contri	ibute to th	ne cause of death?
rds	quires n sign ald be	d b								15 Ye	s 2 🗆 No	3 🗌 Prob	ably 4 □Unknown
Records,	law rec as bee 2 shou	Completed								24a. Was ar	24b. W	Vere auto	psy findings available apletion of cause of
- R	The ate h page	Com								perform 1 ☐ Yes 2	ned? d	eath?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0	da man		Check onl on			
of	F = F	. To	1 Yes 2 No	28a. Date of	Injury 28b.	Time of	IL 3 DOA	4 🗆 14		-/-	nce 6 Other		v)
on	Attending Phy r death. ector: After thi by the funeral o	ation	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury		ork? ∐Yes 2 []No				
Division	al or Atter after des I Director d in by thu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	206. Flace 0	f Injury - At home, fi , etc. <i>(Specify)</i>	arm, str	eet, factory, office	3	28	f. Location (St City or Town		er or Rura	il Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the b niner: On the bas and manne	est of my knowledg is of examination ar r stated.	e, deat	h occurred at the vestigation, in my	time, date a opinion, de	ath occurred	d due to the ca at the time, da	ause(s) and mar ate and place, a	nner as st ind due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				1	se number		2	9d. Date signed		Day, Year)
)			> liblican	^	M		υ	320	009		660	2	
	5		30. Name and address of person who	lithem	of death (Item 23a)	(Type,	evolut	Ton S	3+. H	avre	De Gra	rei	m021678
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 7 2005	32. Reg	gistrar's Signature	de	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registragmend item #19b&20c per fh g849 tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month M Katherine 2005 Warren Sites :10P /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9050 Northbridge Road Be1 Alton Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June Day 4ear) 945 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Maryland Days 1 ☐ M 2 💢 F 59 213-46-5015 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD Charles 1 ☐ Yes 2 🕅 No Bel Alton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 9050 Northbridge Road death 20611 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or the any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lucian Crissey Warren Katherine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre Quid Number or Rural Route Number, City or Town, State, Zip Code) John Sites/Husband P.O. Box 896, Bel Alton, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mt. Hope Crematory 6/10/05 * 4 ☐ Donation 5 ☐ Other (Specify) Bangore, Maine 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. (chu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Hodgkins Lamoloma /Medical De t (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Year Month Day 5 Other (specify) P.O. | ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dnknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death Check on one examiner Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\tag{Homicide} 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and ause of death (Item 23a) (Type, Print) Name and addre

State Registrar tan

6 2005

31. Date filed (Month, Day, Y

istrar's Signature

Ste 104, Waldoof

			1 - For State Registrar		Maryland / Dep Ce	o ar tment of e <i>rtificate o</i>			giene 005	20450
	Physic	ian	Decedent's Name (First, Mide	die, Last)			· -	2. Date of De. Month	ath Day Year	3. Time of Death
	/Medi		Margaret Hele	en Selmser		-		6	5 2005	1:38 A ^M
	Exami	ner	4a. Facility Name (If not institution		or)	4b. City, Town	, or Location of	Death	4c. County of Death	1
			Atlantic Gene 5. Social Security Number		6 // / / /		rlin		Worcest	
\\	Funeral Director		196-18-7253	6. Sex 7. /	Age (In yrs. last birthda)	Months Day		Min. (Month, Da		place (State or Foreign intry)
14			Usual Residence of Decedent		79 Yrs.			10/22/	1925 Yo	ork, PA
	Maryland I-f show		10a. State 10b. Count	у	10c. City, Town or	ocation				10d. Inside City Limits
O	the Mar 28a-f st	tor	PA Yor	k	York				}	1X Yes 2 □ No
2	with the Maryla 6 or 28a-f shov De collified at	Director	10e. Street and Number		TOTAL	10f. Zip Code)		10g. Citizen of What Cou	intry?
200210	23£	alD	2200 Greenbr	iar Rd.		1	7404		USA	
4	ours after death w rel', or Items 23a Erain har must	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13			n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri	
98	or It	Y.F.	1 Never Married 2 Ma	If Vac Give	₹No	1 Yes 2 N		ruello filcali, etc.)		, etc.
8	72 hours "neturel", idical Ex	d by	3 ☐ Widowed 4 ♣ Divorce	Year or Dates					Specify: W	/hite
1215-0036	n 72 "nei	Completed	15. Decede (Specify only high	nt's Education est grade completed)	16a. Dec	edent's Usual Occ e kind of work don DO NOT use reti	upation ne during most o	of working	16b. Kind of Business/Ir	ndustry
22	within ene. then *	mg	Elementary/Secondary (0-12)	College (1-4o	(10+)				D G .	
200	tiled Hygi ther	Ö	17. Father's Name (First, Middle	, Last)		tail Man		s Name (First, Middle,	Retail Sale	es
an/	d be ental	To Be	William Long							
Maryland	shoul nd Ma marl	-	19a. Informant's Name/Relation	ship (Type, Print)	19b. Mai	ing Address (Stre	et and Number of	th Stageme	eyer r, City or Town, State, Zij	n Coda)
38	permit. Pages 1 and 2 should be tiled within 72 ho Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netur any injury or other treumetic event, Item Medical 2008.	1 3	Lynn Selmse			24 Linda				
٠ ē	tem tem		20a. Method of Disposition		20b. Place of Disc	osition (Name of	Lane	Date	lale, VA 220 20c. Location - City or To	
Baltimore,	ages ant of it: if i		1 ☐ Burial 2 ★ Cremation `4 ☐ Donation 5 ☐ Other (9					
Ē	artme artme orten injur		21. Signature of Fun 1 Service		Cape He	niopen (2. Name and Add		6/6/2005	Frankford,	DE
Ba	permil Depar Impor any in		W Strait	2	- 4				bage Funer	al Home
	114		23a. Part1. Enter the disease, o	or complications that cause	ed the death. Do not en	ter the mode of d	ving such as ca	et, Berlin,	MD 21811	Approximate
	Discontinuo		shock, or fleart failure. Lis Immediate Cause (Final	t only one cayse on each	line.	- ^ .	ynig, odoir do od	indiae of respiratory an	631,	Interval Between Onset and Death
	Physician / Medical		disease or condition resulting in death)	-	hemil Co	LITI				
	Examiner			Due to (or a	s a consequence of):					
	· (*)	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<						
Ć,	be executed ician and burial-transit	Exa	resulting in death) Last	c. Due to (or a	s a consequence of);					
8760,	death certiticate be executed e attending physician and od for use as the burial-transit			l d						
9	titicate g phys as the	edi			<u> </u>		200			
ŏ	death certitics attending phater afor use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregrant	23c. If yes, outcom					23d. Date of delive	erv
B	deatle atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant		⊒Ectopic pregnan ⊒ Other <i>(specify)</i> ₋	cy		Month	Day Year
P.0	that the d ed by the detached	hys	9 Unknown	9□ Unknown						
S, F	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditi	ons contributing to death	but not resulting in the	ınderlying cause g	iven in Part I.	23e. Did to	bacco use contribute to the	he cause of death?
rd	w require been sig should b							1 🗆 Y	es 2□No 3□Prob	ably 4 X Unknown
Record	e law requ has been je 2 shouli	Completed						24a. Was a		psy findings available
Ä	0 4 9	E O						autops perform	ned? death?	mpletion of cause of
Vital	ician: Th certiticate rector, pag	O	25. Was case referred to medica	il /			26. Place of	1 Yes		2 □ No
f V	lys dills	To B	examiner? 1 ☐ Yes 2.2 No	Hospital: 1 Inpat	ient 2 ER/Outpatie	nt 3 DOA	thorn		ence 6 Other (Specifi	v)
n of			27. Mann f Death 1 1 atural 5 ☐ Pendii	28a. Date of Inj (Month, D	ury 28b. Time o	of 28c. Inju			w injury occurred	,,
<u>0</u>	Attending r death. ector: Atter	atic	2 Accident investi	igation	-, · · · · · · · · · · · · · · · · · · ·		JYes 2 □ No	1		
Division	or Attend after death Director: /	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of Ir	njury - At home, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or Rura	l Route Number,
	rs aff	Cer			(opcony)			Only of Town	i, State)	
	Hospitel or 24 hours afte 5-unerel Dire tely tilled in t	cai	29a. Certifier 1 Certifyin	Examiner: On the basis	t of my knowledge, dear	h occurred at the	time, date and p	lace, and due to the ca	ause(s) and manner as st	ated.
	To the Hospitel of within 24 hours at To the Funerel Completely tilled in	Medical		and mariner s	tated.			occurred at the time, d	ate and place, and due to	me cause(s)
	vit To con	~	29b. Signature and title of certifie	ar /			ise number	1	9d. Date signed (Month,	Day, Year)
			· Ch	BATEL		DS	53612		6/5/05	
			30. Name and address of person	who completed cause of	death (Item 23a) (Type	Print)	0 .	4: 0 0	: D//	
C	H, 5		Modera K	Daicr 91.	W Itealfl	1 way Rr	Berlin	i, mp 2	15/	
	Sta	te	31. Date filed (Month, Day, Year, JUN 0	7 2005 32. Regist	rar's Signature	. 0		,		
	Registr	aı		- 2003	a B A	medi				

			1 - State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment rtificate	t of H e of L	ealth a Death	and N	lental l	Hygie Reg.		15	20451
			1. Decedent's Name (First, Middle, Last)							2. Date of		Davi	V	3. Time of Death
	Physici		Alexi Dawn Stanba	ck						Month	31,	Day 2005	Yeer	3:40 P M
1	/Medi Examir		4a. Fecility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location of	of Death		31,	4c. County	of Deeth	1
	LXUIIII		Holy Cross Hospit	al		Silv	ær :	Sprin	α			Mor	1tan	mery
87.	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of (Month)	Birth			place (State or Foreign untry)
	Director		220-71-9892	M 2⊠F	O Yrs.	Months 7	Days 8	Hours	Min.	April	23,	2005		aryland
	ס		Usuel Residence of Decedent							1				
	show		10a. State 10b. County		10c. City, Town or Lo	ocation								10d. Inside City Limits
	Ma-f	to	Maryland Ho	ward	Col	ımbia								1⊠Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip	Code				10g.	Citizen of V	hat Cou	intry?
	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f show he Medicul Ener items the codified at		6182 Commadore C	Court		2	21049	5				USA		
	deal	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or Rican, etc.	No-		- Amer	ican Indian,
9	after or Ite	Fu	1 Never Married 2 Marned	1 ☐ Yes 2 🗷 No)	1 ☐ Yes 2		Specify:	,, , , ,	1 110411, 0101	,	Specify	D	lack
8	ours	i by	3 Widowed 4 Divorced	Year or Dates:		1000 2	140	Specify.				Specily		
21215-0036	72 h	Completed	15. Decedent's Edu		(Give	dent's Usua	k done a	turing mos	t of work	cing	168	. Kind of Bu	siness/l	ndustry
2	thin	효	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT us	e retired)						
	ad wi	Co	0		Ne	ever V	Vork					11/1		
p	al Hy	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Nam	e (First, Mic	ldle, Mai	den Sumam	9)	
/a	Ment Ment arked	2	Paul McKinley St	anback				Jo	cely	n Del	ois	Jones		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Medical East the printed by Loudilled at		19a. Informant's Name/Relationship (Ty									ity or Town,		
	and alth		Jocelyn D. Myers-S	tanback/M	other 618	32 Com	mado	ore C	ourt	, Col	umbi	a, MD	210	45
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra once.	-	20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Nam	ne of ther place	9)		ne 6,	200	. Location -	City or T	Town, State
E	Page:	,	1 Burial 2 ☐ Cremation 3 ☐ R 1 Donation 5 ☐ Other (Specify)	emoval from State	Gate of He					2005	Si	lver S	Spri	ng,Maryland
alti	permit. Pa Departmer Important eny injury		21. Signature of Funeral Service License	98 0	ਸਵੇਂ	2. Name an	d Addres	s of Faculit	Ync	Funer		ome Ir	-	
ä	Depariment Department of the property in the p		1 (inches) S	Cole	50	O Uni	vers	ity	Blvd	, W.,	Sil	ver Sp	rin	g, MD 20901
	Q.		23a. Part1. Enter the disease, or comp	cations that caused t	he death. Do not en	ter the mode	e of dying	g, such as	cardiac	or respirato	ry arrest,			Approximate
- 10			shock, or heart failure. List only of Immediate Cause (Final	e cause on each line										Interval Between Onset and Death
78	Physician /Medical		disease or condition resulting in death)		ory Failur	e							-	37 Days
ji)	Examiner				consequence of):									
		<u>.</u>	Sequentially list conditions.	Chronic	Lung Disea consequence of).	ise							0.1	23 Days
	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											~ = -
_	ate be executed thysicien and the burial-transit	xar	that initiated events resulting in death) Last		Prematurit consequence of):	У			-					37 Days
8760,	be e			_ `										
87	cate phys	dlcal		l									-	
9 ×	eath certific attending pl for use as t	/Me	IF FEMALE:	30 If was outcome o	f orognanov									
Вох		ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1□Live birth 2	Fetel death 3	Ectopic pro						23d. Date Mor		very Day Year
O.	0 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me of death 5L	Other (sp	ecity)				_			
Ρ.	a o	by Physician/Me	Part II. Other significant conditions cor	tribution to dooth but	ant consulting in the .	and arbitrar as		n in One I		230 [id tobac	co use contr	ibute to	the cause of death?
s,	es pe	by	Part II. Other significant conditions con	mouning to death but	not resulting in the c	riderlying Co	ause give	en in ran i						bably 4 Unknown
Records,	w requir been si should I	Completed										2421110	3	
Ö	aw is b	pie								24a. V	utopsy	24b. V	vere aut	opsy findings available ompletion of cause of
Ш.	The I	Хоп								1 Ye	erformed s 20	1? d	eath? □Yes	2 No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical					26. Place	of Deat	th (Check or	nly one)			
>	S S	10	examiner? 1 ☐ Yes 2X No	lospital: 🎦 Inpatien	t 2 ER/Outpatie	nt 3 DO	A Othe	er: 4□ Nu	irsing Ho	ome 5 F	lesidence	e 6 □Othe	r (Spec	ify)
J of			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Yeer) 28b. Time o	f 2	8c. Injury Work	at		28d. Descr	be how i	njury occurre	ed	
Ö	Attending r death. actor: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation			М		Yes 2	No					
Division	or Attendation after deall Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, st	reet, factory	, office				n (Stree Town, S		or Ru	ral Route Number,
Ö	al or A s after al Direct	Seri	T I TISMINIS	ounding, oto.	(5,500.14)				- 9	o, o.	7 0, 0			
	hours a nerel C			sicien: To the best of										
	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examination)	ner: On the basis of e and manner state	examination and/or in ed.	vestigation,	in my of	oinion, dea	th occur	red at the til	ne, date	and place, a	nd due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and little of Centifier			29c	License	number		-	29d.	Date signed	(Month	, Dey, Year)
			> XI LANGL	My MD		-	D4	536	9			Ju	ne 2	2, 2005
	1		30. Name and address of person who co	moleted cause of de	ath (Item 23a) (Type						1			
	l		Alan K. Goldberg,		00 Forest		Road	l, Sil	lver	Sprin	ng, M	0 2091	0	
	pr St	ate	31. Date filed (Month, Day, Year)	32. Rigistrar		6.1	,			_	J			
			JUN () 6 2	1115 1000	. 11. 14	MARIN STATE								

			rt III 1- State Unpend Item Registrar 1. Decedent's Name (First, Middle	a 23a&27 per	me 6044	Certificate d	of Death	2. Date of D		2005	2045
	Physici /Medic		Oather Harr	, - ,	t III			June	Day	Year 2005	3. Time of Death 6:32. P
	Examir	ner	4a. Facility Name (If not institution, Malcolm Grow H				n, or Location of Dea Springs	uth		County of Death	
99	Funeral Director			6. Sex 7. Age 1 1 1 2 1 F	(In yrs. last birthe	day) If Under 1 Yours. Months Da			Birth	9. Birth	place (State or Foreigr intry) Wash DC
,	the Marylan 28a-f show cuilled at	Director	MD 10a. State 10b. County Prince 10c. Street and Number 10c.		Suitla		40		10g Citiz	en of What Cou	10d. Inside City Limits 1 XYes 2 No
	23a or			Park Cour	t	2074				S.A.	mitry ?
9800	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or items 23e or 28e-f show avent, the Medical Examination must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specity:</i>	Specity Yes or Note Rican, etc.)		4. Race - Ameri Black, White Specify: Bl a	
Maryland 21215-0036	d within 72 h giene. ir than "natu	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12) 12		\ (i)	Decedent's Usual Od Give kind of work do ife. DO NOT use re reho use	one during most of w tired)	orking rvisor	16b. Kind	d of Business/ir	ndustry
land		To Be C	17. Father's Name (First, Middle, L Oather Harr	ast) is Stewart	Jr			ame (First, Midd Ann V			oughtie
	ind 2 should alth and Men 27 is marks ar traumatic		19a. Informant's Name/Relationsh Yulonda Tyeas	nip (Type, Print) se England	Stewart	Mailing Address (Str	reet and Number or F	Park (ober, City or Court	Town, State, Zi,	
altimore,	Pages 1 and 2 nent of Health int; If itam 27 i iry or othar tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemetery,	Disposition (Name of crematory or other dale Par	place)	Date 3/05		ation - City or T	
Baltii	parmit. Pages Department of Inportant: If its any injury or of		21. Sig ature o Funeral Service I	n	Da Do.		dress of Facility		Laug	hlin's	Funeral
E			23a. Part1. Enter the disease or shock, or heart failure. List	omplications that caused find one cause on each line	he death. Do ho		Har			NE, Was	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition	01	0						Opent and Dooth
			resulting in death)	a. <u>Obesity</u> Due to (or as a	consequence of):				2	Onset and Death
	Examiner	ner	Sequentially liet conditions	Due to (or as a	consequence of					2	Onset and Death
	Examiner pu Lausit	Examiner		b. Due to (or as a b. Due to (or as a c.):					Onset and Death
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P.O. Box 68760,	Examiner pu Lausit	by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 1995 (Leade of Infla) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 \(\triangle	consequence of consequence of f pregnancy	3 □Ectopic pregnt 5 □ Other (specify)			Month e contribute to t	Onset and Death
P.O. Box 68760,	we requires that the death certificate be executed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Coales. (Listocae of Inflat) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 \(\triangle	consequence of consequence of f pregnancy	3 □Ectopic pregnt 5 □ Other (specify)	1 24a. Wa	f tobacco use	Month e contribute to t No 3 Prol 24b. Were auto prior to codeatty	ery Day Year
P.O. Box 68760,	we requires that the death certificate be executed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as a d. Pregnant at ti 9 Unknown ns contributing to death but	consequence of) consequence of) f pregnancy Fetal death me of death not resulting in the	3 Ectopic pregna 5 Other (specify the underlying cause the underlying ca	26. Place of De Other:	1 24a. Wa	tobacco usi	Month e contribute to to the prior to condeath of the prior to condeath of the prior to condeath of the prior to condeath of the prior to condeath of the prior to condeath of the prior to condeath of the prior to conde	ery Day Year he cause of death? bably 4 □Unknown apply findings available impletion of cause of 2 □ No
P.O. Box 68760,	hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and til director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Liscold or injury) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions.	Due to (or as a b	consequence of) consequence of) f pregnancy Fetal death me of death not resulting in the	3 Ectopic pregns 5 Other (specif) he underlying cause attent 3 DOA	e given in Part I. 26. Place of De	24a. Wa aut per Yes	i tobacco usi] Yes 2 disan opsy formed? 2 \(\text{No} \)	Month e contribute to to to to to to to to to to to to to	ery Day Year he cause of death? bably 4 □Unknown apply findings available impletion of cause of 2 □ No
vision of Vital Records, P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed to the death. The death. The death of the certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	To Be Completed by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 1938 (Listable of Inflat) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a b	consequence of) consequence of) f pregnancy The Fetal death the of death the of death the consequence of) the pregnancy The pregnancy	3 Ectopic pregns 5 Other (specif) he underlying cause attent 3 DOA	26. Place of De Other: 4 Nursing niury at Work?	24a. We aut per Yes seth (Check only Home 5 Re: 28d. Describe	is an opsy formed? 2 No rone) sidence 6 e how injury	Month e contribute to t No 3 Prol 24b. Were autoprior to clear to reach to reach the contribute of	ery Day Year he cause of death? bably 4 □Unknown apply findings available impletion of cause of 2 □ No
vision of Vital Records, P.O. Box 68760,	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and adely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig 1 Yes 2 Accident 2 Accident 3 Suicide 4 Homicide 1 Certifying 29a. Certifier 1 Certifying 29a. Certifier 1 Certifying 20 Accident 1 Certifying 29a. Certifier 1 Certifying 20 Certifying 20 Accident 1 Accident 20 Ac	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown ns contributing to death but Hospital: 1 Inpatien 28a. Date of Injury (Month, Day ation oot be 28e. Place of Injure	consequence of) consequence of) f pregnancy Fetal death me of death not resulting in the state of the sta	3 Ectopic pregna 5 Other (specify the underlying cause the underlying cause the underlying cause the underlying cause the underlying cause the underlying cause the underlying cause the underlying cause the underlying	26. Place of De Other: 4 Nursing niury at Work? 1 Yes 2 No ice	24a. We aut per Yes eath (Check only Home 5 Re: 28d. Describe 28f. Location City or T.	Is an oppy formed? 2 No rone) sidence 6 e how injury (Street and own, State)	Month e contribute to t No 3 Prol 24b. Were autorifor to codeath 1 Yes Other (Special coccurred) Number or Run nd manner as s	ery Day Year he cause of death? bably 4 Unknown psy findings available impletion of cause of 2 No fy) al Route Number,
vision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed to be detected as the death. Director: After this certificate has been signed by the attending physician and min by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 1913 (Listone or injury) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as a d. Pregnant at ti 9 Unknown Hospital: 1 Inpatien 28a. Date of Injury (Month, Day ation tot be 28e. Place of Injury building, etc. g Physician: To the best of Examiner: On the basis of a	consequence of) consequence of) f pregnancy Fetal death me of death not resulting in the state of the sta	3 Ectopic pregna 5 Other (specify the underlying cause the underlying ca	26. Place of De Other: 4 Nursing niury at Work? 1 Yes 2 No ice	24a. We aut per Yes eath (Check only Home 5 Re: 28d. Describe 28f. Location City or T.	I tobacco using the state of th	Month e contribute to t No 3 Prol 24b. Were autorifor to codeath 1 Yes Other (Special coccurred) Number or Run nd manner as s	ery Day Year the cause of death? bably 4 Unknown pasy findings available impletion of cause of 2 No fy) al Route Number, stated. o the cause(s) Day, Year)

DHMH 17 Rev 1/2001

		For State Registrar			State o	тмагу			artmen rtificat				lental H	ygien Reg. N		مراد فراد	1 07 08
Physiciar /Medica		Decedent's Nam YAV		le, Las	SEFAI	·							2. Date of I Month MAY		ay Yea 2005	1	of Death () 41 P M
Examine		PRINCE 5. Social Security I	GEORGE		HOSPITA	AL	ı yrs. last bin	Maria est		VERL		of Death	0.5.4.41		c. County of De	GEORGE	
Funeral Director		N/A Usual Residence of			∑ M 2□F	38		Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, I Octob	Day, Year er 1	1,966 9 8 0 Gha	irthplace (Stat Country) Ina	e or Foreign
Maryland f show	101	10a. State	10b. County		George's		c. City, Towr			hts							City Limits
with the Maryla or 28a-f shore	Direc	10e. Street and Nu					-		10f. Zip	Code					itizen of What (
. 0	by Funeral Director	7115 Wi1 11. Marital Status 1 Never Mar 3 Widowed	ried 2. ★ Mai	ried	12. Was Deci Armed Fo 1 Yes If Yes, Gin Year or D	rces? 2 No ve	r in U.S.		Was Deced If Yes, spen 1 ☐ Yes	city Cuba	spanic O	n, Puerto	ecify Yes or f Rican, etc.)		na, West 14. Race - An Black, Wr Specify:	nerican Indian,	
5 2 7	Completed		15. Deceder cify only highe	nt's Ed			16a.	Dece (Give life.	dent's Usua kind of wo DO NOT u	al Occupa rk done d se retired	ition fu <i>ring</i> mo	st of work	ing	16b.	Kind of Busines		
filed with Hygiene. other than			l2th	Last)	College (Pı	of	essio	nal .	-		e (First, Midd		ivate		
and Mental Hygin is marked other eumatic event, I	000	James Ki			nkor						_	ace (e, Maide	n Sumame)		
id 2 sho ith and 27 is ma treum	ì	19a. Informant's N				,								_	or Town, State,		
jes 1 ar of Hea of Hea if item 3			position Cremation	3 🗆	Removal from	2	Ob. Place of cemeter	Dispo	sition (Nar natory or o	ne of ther plac	9)	I	Date	20c. l	ocation - City o	r Town, State	
permit Pages 1 ar Department of Hea Importent: If item any in ury or other once.		` 4 □ Donation 21. Signa ure of	_				Gate	22	. Name an	d Addres	s of Facil	6/25/ y J. Road	B. Je	nkir	lver Spr ns Funer Marylar	al Hom	e
Physician /Medical		23a. Part1. Enter shock, or hea Immediate Cause disease or conditi- resulting in death)	in failure. List (Final on	comp only o	lications that cone cause on e	aused the ach line.		ot ent		e of dying	, such as	cardiac		arrest,		Approxim Interval B Onset an	ate letween
ilicate be executed a physician and as the burial-transit	cal LAg	Sequentially list or if any, leading to if cause. Enter Under Cause (Disease that initiated event resulting in death)	onditions, nmediate erlying injury s	{	b. 9000 Due to (or as a co	nsequence of nsequ	501	NATI	on:	1 7	187 1ND	ROM	o si	IN DROM	20 6	TRS
death cert e attending d for use a	N I I	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2	months? ⊒No			irth 2 🗀 ant at time	Fetal death		Ectopic pr						23d. Date of de Month	elivery Day	Year
w requires that the been signed by the should be detache	a ka na	Part II. Other signi		_				the ur	nderlying c	ause give	n in Part	l.			use contribute	to the cause of	
The law ate has b page 2 sl		1-11	V		DIAC	481	8							s an opsy formed?	prior to death?	utopsy finding completion of s 2 No	s available cause of
ng Phys tter this ineral di	2	25. Was case reference examiner? 1 Yes 2 27. Manner of Deal 1 Accident	No	ıg.	28a. D te d		2 ER/Out 28b. Ti			8c. Injury Work	r: 4□Ni	ırsing Ho	n <i>Check only</i> me 5 ☐ Res 28d. Describe	idence	6 □Other (Spe	ecity)	
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funers Medical Certification:		3 Suicide 4 Homicide	6 🗌 Could determ	not be ined	28e. Place buildir	of Injury - ng, etc. (S	At home, far pecify)	m, stre	eet, factory	, office			28f. Location City or To	(Street a own, Stat	nd Number or F e)	iural Route Nu	ım <i>ber</i> ,
ne nospi n 24 hour he Funer pletely fill		29a. Certifier (Check only one)	Certifyir 2 Medical	g Phy Exami	rsician: To the iner: On the ba and mann	asis of exa	/ knowledge, mination and	death /or inv	occurred restigation,	at the time in my op	e, date ar inion, dea	id place, a	and due to the	cause(s	and manner a d place, and du	s stated. e to the cause	r(s)
To To the common of the common		29b. Signature and	d1	10	ma	yuo.			1	License	Q10	75		00	ate signed (Mon	5-0	5
23	_	DAV / D		900	ompleted caus	of death	(Item 23a) [γρ _{0, 1}	Print) P	100	CAO	JT K	E	CNI	LARGU	, MD	20774
State Registrar		31. Date filed <i>(Mon</i>		005	F. R.	egistrar's S	Signature	bos	les								

DHMH 17 Rev 1/2001

	N.		For State	State of Marylan		artment of H			iene _{9, No.} 2005	20454
يحن	w . W	3	Registrar 1. Decedent's Name (First, Middle, Las	st)	1	timodito or a		2. Date of Deat	th	3. Time of Death
	Physicia		Romapuplt	Sinde	ton			05 3	Day 2005	-002 \ M
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	ath	4c. County of Deat	h
			Southern Mary	land Hospital			linton			George's
	Funeral		Social Security Number 6. S	CNA 2CIE		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	1. (Month, Day,		hplece (State or Foreign untry)
	Director	}	578-52-3514 Usual Residence of Decedent	6	5 Yrs.			Jan. 1,	1940 W	ash., DC
	land		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	Mary Fr sh	to	Maryland Prince	George's		T	Jpper Ma	rlboro		1 DXYes 2 □ No
	r 28s	Director	10e. Street and Number	ocorpe o		10f. Zip Code	P P S A A A A A A A A A A A A A A A A A		0g. Citizen of What Co	untry?
	th wit		2949 Chest	er Grove Road			20774		United	
	rdea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- arto Rican, etc.)	14. Flace - Ame Black, Whit	e, etc.
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	rican
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show ther than "natural", or Items on 18 he rollified at	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business/	erican Industry
 	n "na	plet	(Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	luring most of w	orking		
212	d with giene or the	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Computer	Analyst		Gov	ernment
g	m - 0 5	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, I	Maiden Sumame)	
<u>a</u>	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. In marked other than "natural", or Items 23s or 28s-f show unatte event, the Medical Francher must be robified at	2	James Bre	vard					ces Single	
a	2 shc and is m		19a. Informant's Name/Relationship (, City or Town, State, 2 r Marlboro	
	1 and Health em 27	1	Joyce A. Harris/D			sition (Name of	GLOVE		20c. Location - City or	
altimore,	Pages nent of t int: If ite		1 Burial 2 Cremation 3	Removal from State	emetery, crei	matory`or other place		7/2005	,	
트	artmentant ortant injury		* 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licen			Crematory Name and Addres			Clinton uneral Hom	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex) John IT. S	tewar III	. 1				Wash., DC	20019
K	N - 2 4		23a. Part . Enter the disease, or com shork, or heart failure. List only	plications that caused the death	n. Do not ent	er the mode of dying	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Gause (Final disease of condition	Acuto	MU	ncardin	1 Pm	terchin		Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequ	uence of)	1		1		
6.	Examiner		Sequentially list conditions.	b. /Wy	DY	4515	544	od vorine	/	
	be sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	Cupala	(Chan	11/	
	and and il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):	ACIDON	W	nage		
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit			Cota	mar	1 Arto	u dir	care-		
9	ificate p phys as the	edic		u	(1		Tour			
Вох	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of del	,
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Other (specify)			Month	Day Year
о. О	that the de ned by the a detached f	Physician/Medical	9 Unknown					20 a Did tob		the equal of death?
ŝ	w requires that s been signed t s should be deta	by	Part II. Other significant conditions of	ontributing to death but not rest	uiting in the u	nderlying cause give	en in Part I.		oacco use contribute to es 2□No 3□Pr	
orc	requi	eted	_ CITIONIC OL	STUGIUS	Wax	MINOR	/			
3ec	nelaw hast ge 2 s	Completed			V			24a. Was a autops	n 246. Were at prior to a death?	topsy findings available completion of cause of
a	ician: Th certificate rector, pag		05.14							2 No
⋚	Attending Physician: or death. ector: After this certification in the funeral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Ño	Hospital: 1 Inpatient 2	ER/Outpatier	ot 3 DOA Othe	20	eath (Check only on Home 5 ☐ Reside	ence 6 ☐Other (Spe	cufy)
Division of Vital Records,	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	
0	tending death. stor: Aft	atio	1 Accident 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □ No			
Σİ	or Attending after death. Director: After in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		2-				1			
	Hosp 24 ho Fune stely f	edical	29a. Certifier Certifying Ph (Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my or	ne, date and pla oinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier	Gus Amits	Dri h	10 29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
	->-0		1 / fund		Ur1.1	מחמשו	6770	0 1	May 30	2005
	000		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	Val		1	0,000
	1 W		A	MIL SURI	7503	Surratt	S. Clir	iton, MI	20735	
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signa	lture /	El		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1800 JADE SELBY 2005 JUNE IMANI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAltimore 11 HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) VIRGINIA If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 518-39-3822 1 ☐ M 252FF Yrs. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County or Itams 23a or 28a-f ehow ASITBURN event, the Medical Examiner must be notified at 1 ☐ Yes 2 No VA LUYDOGN Funeral Director 10g. Citizen of What Country? 10e. Street and Number HEDGE APPLE 45A 2014 42960 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 27 No 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 25 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural', Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A D 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hisht; If Itam 27 Is marked oth Lewis AJYANA 5607 traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42966 Hedge Afflet et ASHB4RH UA 9 19a. Informant's Name/Relationship (Type, Print) ASHBURN UA 20149 (FATHER other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Nation 3 ☐Removal from State 10/05 Vew Jersey AIR LAWN ö permit. Page Department of Important: If any injury or once. CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STEPLING 21. Signature of Funeral Service Lice STEVLING se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dise shock, or heart faily Immediate Cause (Find disease or condition resulting in death) days DUMBANCES Physician SEVERE ELECTROLYTE /Medical Due to (or as a consequence of). Examiner END STA GE KEWAL DISFATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner 19 weeks The law requires that the death certificate be executed burial-transit LYMPHANGIECT ASIA PULMONARY Due to (or as a consequence of): Box 68760, attending pl 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Year Month in the past 12 months? 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown ANASARCA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EDEMA PULMONARY autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No EFFUSIONS A BURAL 26. Place of Death | Check only one Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) Time of 28d. Describe how injury occurred funeral Injury at Work? 27. Manner of Death After t 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: Certification: after death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To tha Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and BALTIMORE ND 21287

DHMH 17 Rev 1/2001

State Registrar

JUNE

2005

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** GENEVIEVE THOMPSON JUNE 2005 3:53 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1614 Village Green Drive Prince George's Landover H Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 9. 7. Age (In yrs. last birthday 5 Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🕱 F Virginia September 23 229-82-3205 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinal must be notified at 1X Yes 2 □ No Director Prince George's Landover 1. the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 U.S.A. 1614 Village Green Drive Funeral death . 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify. þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Private Housewife 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event gone. Be Bettine Brasifield William Douglas Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1614 Village Green Dr.Landover, Maryland 20785 Daniel G. Thompson/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/6/2005 Riverdale, Maryland ¹ 4 ☐ Donation 5 Other (Specify) Riverdale Crematory 21. Signature of Fursial Soci ce Licensee 22. Name and Address of Facility J. B. Jenkins FuneralHome 7474 Landover Road Landover, Maryland 20785 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease Immediate Cause (Final disease or condition resulting in death) Ketoacidosis **Physician** /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, ician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Month Day Year for in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed' 1 ☐ Yes 2 X No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3□ DOA į P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after deat 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ģ 4 | Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only onel within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8416 Central Avenue Landover, Maryland 20785 Ophnell Cumberbartch M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 7 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla	nd / Depa	artment o	of Health and	•	/111	5 20457
			Registrar 1. Decedent's Name (First, Middle, La	uet)	Ce	runcate (or Death	2. Date of D	Reg. No.	3. Time of Death
	Physici	an		•				Month	Day Ye	ear
	/Medio		John Daniel T 4a. Facility Name (If not institution, given			4h City Tow	m, or Location of Dea	June	1 20	7.30 11
×	Examir	er	Prince George			ab. oity, ron	Cheverly		,	ce George's
	Funeral				s. last birthday)	If Under 1 Y	ear If Under 24 Hr	s. 8. Date of B	rth a	Birthplace (State or Foreign Country)
	Funeral Director			1 □MM 2 □ F	81 Yrs.	Months Da	ays Hours Mir		ay, Year)	Virginia
**	D		Usual Residence of Decedent						1,01	
	rylar	_	10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f.	cto		George's			nellville			1 XYes 2 No
	or 2	Dire	10e. Street and Number			10f. Zip Co			10g. Citizen of Wha	t Country?
	eth w	ra R	1009 Kings Va	T			20721			d States
	er de	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 14. Hace - / Black, \	American Indian, White, etc.
36	rs aft	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐XYes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2 □	No Specify:		Specify:	African
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-1 show int, the Maulical Examiner must be notified at	Completed by Funeral Director	15. Decedent's E		16a. Dece	dent's Usuai O	cupation		16b. Kind of Busin	American ess/Industry
15	n "ne	piet	(Specify only highest gr	ade completed)	(Give	kind of work do DO NOT use re	one during most of w	orking		,
212	iene r tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 2		Aircra	ft Engine	er	Gove	rnment
	othe	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle	, Maiden Sumame)	
<u>a</u>	uld by Aenta rked ric ev	To E	Carrol1	Edward Tyree				Ethe	1 Weaver	
Maryland	and h		19a. Informant's Name/Relationship (**	100				er, City or Town, Sta	
	and 2 salth n 27 i		Lillian Ann Tyr				-	-	ellville,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crei	osition (Name o matory or other	place)	Date	20c. Location - City	or Town, Stete
Ē	Pag ment ant: ury c		4 ☐ Donation 5 ☐ Other (Speci	(y) F	t. Linc	oln Cem	etery 6/8			wood, MD
äat	Depart Depart Import any inj		21. Signature of Funeral Service Lice	nsa)					Funeral Ho	
<u> </u>	205 2 3		18hw 1.	If show y					ash., DC 2	
ŧ			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not ent	ter the mode of	dying, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cluse (Final disease or cendition	Cerebrov	ascular	Accide	nt			20 Days
×	/Medical Examiner		resulting in death)	Due to (or as a conse						
	LAUITINICI	L	Sequentially list conditions,	b. Hyperten:						30 Years
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equerice oi).					
_	te be executed ysicien and le burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					
760,	be e	calE								
687	# × @			_ d						
×	that the death certifical ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date of	delivery
Вох	death atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		∃Ectopic pregna ∃Other (specif)			Month	Day Year
P. 0.	the cy the	hys	9 Unknown	9□ Unknown						
<u>ر</u> ت	s that	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
ğ	w requires to been signer should be	edt	Diabetes	Mellites - In	sulin D	ependen	t	1 🗆	Yes 2∭ No 3[Probably 4 Unknown
Records,	aw ress bec	plet	Renal Fai	lure				24a. Was	an 24b. Wer	a autopsy findings available to completion of cause of
æ	The law requires that the death certifica tate has been signed by the attending ph page 2 should be detached for use as the	Completed	Coronary	Artery Diseas	<u> </u>				ormed? deat	h? Yes 2 No
Vita	ician: Th certificate rector, pag	0	25. Was case referred to medical examiner?	Artery Disease	<u> </u>		26. Place of De	eath (Check only	77	
>	Attending Physician: or death. ector: After this certifics by the funeral director. I	To B	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 Ninpatient 2	☐ ER/Outpatien	nt 3 DOA	Other: 4 - Nursing	Home 5 ☐ Res	idence 6 Other (5	Specify)
Division of	ding Pt h. After th funeral	ä	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. l	njury at Work?		how injury occurred	
Sio	endii eath. or: A he fu	atic	2 Accident investigatio			М	1 ☐ Yes 2 ☐ No			
Ξ̈́	l or Attenu after deatl Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, off	ice		Street and Number o wn, State)	r Rural Route Number,
Ω	urs af							1		
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Example 12 Medical Example 2 Medical Example	nysician: To the best of my ke miner: On the basis of examin						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number		29d. Date-signed M	onth. Dav. Year)
}	T with		N Kun	lectof		1	16273	MO	6/1/0	3
Δ.	(10)		10/Marmo and address of access	completed saves of death (%)	am 23a) /Tune	Print)			0/11	
K	- (1)		31. Date filed (Month, Day, Year) JUN 0 7 2005	CATAY	6/30	LAN	DOVER	YED,	CHEV	LPLY, MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature /	40				
	Registr		JUN 0 7 2005	Helder 15	Local					

			State of Ma 1 - State AMEND#23 per MD,6/6/05,DE		artment of Health and N		ene	
			Hegistrar 11	5,1200 001	inoato or Boain	2. Date of Death	4. 11	3. Time of Death
4	Physicia		John K. Vance			Month May	27 2005	4:45 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Dea	
			Wilson Health Care Center		Gaithersburg		Montgo	mery
	Funeral		1571 055	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	Year) 9. Bin	thplace (State or Foreign ountry)
	Director		307-09-7000	89 Yrs.		Oct. 3,	1915 N	E
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	the Marylar 28a-f show	tō	MD Montgomery	Gai	ithersburg			1 ☐ Yes 2 🗓 No
	r 28a	irec	10e. Street and Number		10f. Zip Code	10	g. Cîtizen of What Co	ountry?
	23a or	a D	301 Russell Avenue		20877		United St	tates
	items	Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 13. V	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	or it	by Fu	1 ☐ Never Married 2 🕅 Married 1 📉 Yes 2 ☐ N	O TATLAT T	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
215-0036	n 72 hours after death with the Maryland "neturel", or items 23e or 28e-1 show idical Examinat must be indiffed at	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Deced	dent's Usual Occupation	11	6b. Kind of Business	
7	in 72 "n" r	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of work DO NOT use retired)	king	ob. Ring of business	maddiy
212	within Jiane.	E O	Elementary/Secondary (0-12) College (1-4or 5-	+)	Librarian		C	IΑ
	a filed II Hyg othe /ent,	Be C	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	18. Mother's Nam	e (First, Middle, Mi	aiden Sumame)	
<u>a</u>	uld by Menta Irkad Itic ev	To E	John E. Vance	Margare	t Kilbour	n		
Maryland	12 should be filed within n and Mental Hygiene. Y is marked other than "reumatic event, the Meg		19a. Informant's Name/Relationship (Type, Print)		City or Town, State, .			
	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 is marked other than "netural", or items 23e or 28e-f sho other treumatic event, the Medical Examinar must be in Allike's at		Elizabeth E. Vance/ Wife			MD 20877		
Baltimore,	iges 1 or of H or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren Metropoli	natory or other place)	28	0c. Location - City or	
Ë	tmen tmen tent:		`4 □Donation 5 □ Other (Specify)	Metropoli Crema				Virginia
Bal	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is any injury or other tre		21. Signature of Funeral Service Livens, e		Peer Park Drive, G	DeVol Fi	uneral Homurg, MD 20	ne, 10 East)877
4			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin immediate Cause (Final disease or condition	θ.	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		resulting in death)	a consequence of):	1.0000			C PA DI COL
	Examiner		Dementia	with anonex	ia			
	B ≅	ner	Sequentially list conditions, and a limit of the cause. Enter Underlying Cause (Disease or injury	a consequence of):				
	and trans	Examiner	that initiated events c.	a consequence of):				
8760,	cate be executed physician and the burial-transit	E E	Due to (b) as a	a consequence or).				
87	physicate physicate	dicai	d					
Box 6	leath certifica attending ph d for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome				23d. Date of de	livery
B.	that the death cer ed by the attendir detachad for use	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
P.0	it the by the tacha	hys	9 ☐ Unknown			-		
Records, F	Se us	Completed by F	Part II. Other significant conditions contributing to death be a contributing to death be a contributing to death be a contributing to death be a contributing at the contribution of the contributions of the contribution	ut not resulting in the u	moderlying cause given in Part I.	23e. Did toba		o the cause of death?
202	w require been si should i	ete	heart failure abst	ruiter	u who with	24a. Was an	24b. Were a	utopsy findings available
Re	The lar	mc	chronicanina	1 a ide	menter of	autopsy	ed? prior to death?	completion of cause of
Vital		ပိ	25. Was case referred to medical		26. Place of Dea	1 Yes 2 th (Check only one		2 140
>	Physician: this certifical director,	ToB	examiner?	nt 2 ER/Outpatier	Othon			ecify)
Jou	ding Phys	L.	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injur (Month, Day	28d. Describe hov				
<u>0</u>	Attending r death. sctor: Afte	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	i Dig	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
	To the Hospital within 24 hours a To the Funeral completely filled	a C	29a. Certifier 1 Certifying Physicien: To the best of					
	the Hc in 24 I he Fu pletely	edic	(Check only 2 Medical Exeminer: On the basis of one) and manner sta	tod				
	To t	Σ	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Mon	th, Day, Year)
			IN Kallet Insell	02(42)	104115	//	nay 27	, X005
l	0+1		30. Name and address of person who completed cause of do IX-ROBERT BIRSCLABIL	eath (Item 23a) (Type, LLL, ULL)	Print) 201 RUSSE, 6417 HERSS	LLAVE, U	10 201	71
	Sta Registi	ate rar	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of did to the CL	ar's Signature	garde			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Robert Scott Wildman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany HOSPITAL moscani hored Heart If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 40 Months Hours XXM 2 F 216-92-6226 1964 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits t0b County 10a State other traumatic evant, the Medical Examiner must be notified at Allegany MD. Westernport 1 Tyes 2000 Director 28e-f 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ŏ 25801 Shady Lane 21562 United States 238 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes Store Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) never worked 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Robert Wildman Sandra Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Pages 1 and 2 Robert Wildman / father 16168 Maryland Highway, Swanton, Maryland 21561 Health em 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> 06/16/ 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 0 Swanton, Maryland Department of Importent: If any injury or once. Mt. Zion Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIO MYODATALY SYEMS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence off by Physician/Medical Examiner frany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 ☐ Yes ACO. PC B.F.S Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 X No 3 DOA 1 npatient 2 ER/Outpatient 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident after death. 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

24 hours a

within 2 To the

29a Certifier

(Check only one)

29b. Signature and title of certifies

31. Date filed (Month, Day

DR. Kobert Welik

Year)

71489OK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Medical

900 SETON DRIVE

CM -

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Camberland, ND

29d. Date signed (Month, Day, Year)

SUNE 14 2005

			1 - For State Registrar	State of Maryla	-	artment rtificate				Reg. No	005	20460
	Physic		1. Decedent's Name (First, Middle, Las Kimberly	PAGE	Wh	etse	11		2. Date of De	ath Day	2005	3. Time of Death 1520 PM
	/Medi Examii		4a Facility Name (If not institution, give		. \			ation of Dea	th	4c. Co	ounty of Death	
			5. Social Security Number 6. S	INS HOST IT	s. last birthday)	If Under 1	imo(Jnder 24 Hrs	8. Date of Bir	th	9 Rinth	place (State or Foreign
	Funeral Director			□ M 2001 E	22 Yrs.			ours Min		y, Year)	32 Te	place (State or Foreign Intry) XAS
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation						10d. Inside City Limits
	e-f sh	ctor	Maryland Montgome	ery]	Potomac							1 ☐ Yes 2 XNo
	with the	Director	10e. Street and Number			10f. Zip C					n of What Cou	
	death ms 23	Funerai	10901 Tara Road 11. Marital Status	12. Was Decedent Ever in	U.S. 13.		0854 t of Hispan	ic Origin? (Specify Yes or No rto Rican, etc.)		ted Sta	ican Indian,
36	or Ita	by Fui	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give	1	rres, specily 1 □ Yes 2≹		exican, Fue ecify:	to Alcan, etc.)		Black, White	
9	2 hour atural	ted b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ec		16a. Dece	dent's Usual (Occupation			16b. Kind	of Business/Ir	ite ndustry
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show the Medical Examination until be indiffed at	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work DO NOT use	retired)	g most or wo	orking		0-11	
N	filed w Hygier other ti		17. Father's Name (First, Middle, Last)	2		tudent		Mother's Na	me (First, Middle,		College (mame)	e
ylan	2 should be filed within and Mental Hygiene. Is markad other than aumetic evant, Items	To Be	Paul V	Whetsel	1				Jane	Mor	ntgomer	У
ā	d 2 sho		19a. Informant's Name/Relationship (19aul W. Whetsell/	**					mac, Mar			p Code)
Ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or Itams 23a or 28a-1 show important: If itam 27 is marked other than "natural; or Itams 23a or 28a-1 show any Injury or other traumatic event; the Medical Expiritive routified at ADER.		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of	, FOLO	Date Mai		tion - City or T	own, State
Baltimore,	Page Iment tant: If jury or	-	1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify) A1	1 Souls	Cemet	ery		e 6,2005	Germa	antown,	Maryland
Ball	permit. Pages 1 and 2 Department of Health s Important: If Itam 27 is any Injury or other tre QDCe.	-6	anature of Funeral Service Licent	Ileelee	10		Deer	Park		thers		MD. 20877
	Physician	5	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the dea		er the mode o	of dying, su	ch as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 7 days
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	~)`e						22 years
	7 =	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):							- /
	e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	equence of):					-		
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x 68	entifica ding ph		IF FEMALE:	23c. If yes, outcome of pregu	nanov							
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fe' 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic preg Other (spec				230	J. Date of deliv Month	ery Day Year
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions o	ontributing to death but not re	esulting in the u	nderlying cau	se given in	Part I.	23e. Did t			he cause of death?
	The law requate has been page 2 should	Completed									24b. Were auto prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of 2 No
Vital	Physiclan: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor		ath (Check only o			
of	Phys rthis ral di	n; To	1 Tes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	□ ER/Outpatien 28b. Time of Injury		Injury at Work?	☐ Nursing I	Home 5 Resident			fy)
sion	Attanding F er death. ractor: After by the funera	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 🗌 Yes	2 🗆 No				
Division	after d after d Diract	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, o	ffice		28f. Location (S City or Tov		lumber or Run	al Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	edical C		ysician: To the best of my kr niner: On the basis of examin and manner stated.					1		1 1	
	To the To the comp	W	29b. Signature and title of certifier			29c. L	icense num	nber		29d. Date s	igned (Month,	Day, Year)
			30. Name and address of person who	completed cause of death flee	am 23a) /Tupo	Print)	25 TO	100	181-1"	June Nu-L	5,2	cos Se stroot
	5		Robert Stephens,	MD Johns He	opkins Ho	spital	Doctor.	s Loung	se Ba	Itimor	re, mar	yland 21287
Ē	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 6	completed cause of death (Ite	the A	perti						

Amend Item 1 per doc, item 5 per int go4/Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, 9:45 A Ruby Ovella Arnett June 2005 Arnett Ovellia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Essex 309 Stillwater Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 ☑ F Yrs Director 238-38-2371 Jan. 17,1927 West Virginia Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State t0h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. It a Modical Examinar must be notified at 1 Yes 2X No Director Essex Maryland Baltimore 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number with 309 Stillwater Road 21221 United States death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2XXNo
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 byr 1 ☐ Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene 7 is marked other than "ni Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Machinist Westinghouse Corp. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lula V. Payne Joseph P. Broughman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun once. Mrs. Diane Pearson (Daughter) 124 Dihedral Drive Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 NOther (SpecifyEntombment Gardens of Faith Cem. 6/17/2005 Rosedale, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Duda-Ruck Funeral Inc. 21222 MINE me art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): artery disease Examiner 10 yz1 or Sequentially list conditions. Due to for as a consequence of : Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physiclan Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ģ in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. | the a detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 25 No 2□ No 1 Yes To the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JUNE 13, 2005 122620 X & 6830 HOSPITAL DRIVE, BALTIMORE MD 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAEED MD, SHAHID 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2 4-4 2005

		•	For State Registrar	State of M	larylar		artment <i>rtificate</i>			Mental Hy	giene () Reg. No.	05	204	62
	Discostati		1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath Day	Year	3. Time of	
	Physici /Medio			Bobby	Ray	Anders	on, Jr			June	08	2005	7:30	P M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, T	own, or	Location of Dea	ath	4c. Cou	inty of Death		
			Sinai Hospital					1tin				N/A		
	Funeral		5. Social Security Number 6. S	Gex 7.A IOXM2□F	. ,	. last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hi Hours Mi	n. (Month, Da	y, Year)	9. Birthp Cour	lace (State o	r Foreign
	Director	-	217-84-3127 Usual Residence of Decedent		35	113.				4-11	-1970		Md	
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation		-			1	0d. Inside Cit	ty Limits
	Mary fied	to	Md	N/A	R	alto							1 📉 Yes	2 🗌 No
	h the Maryland r 28a-f show andiffied at	Director	10e. Street and Number	14/11		4100	10f. Zip (Code			10g. Citizen	of What Cour	ntry?	
	h with 23e or st Le		1236 Meridene D	rive					212	39	U	S A		
	itams ?	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in l	J.S. 13.	Was Decede	ent of His	spanic Origin?	Specify Yes or No- orto Rican, etc.)	- 14. F	Race - Americ Black, White,		
9	or its		1 Never Married 2 Married	1 Tes 2 X	[No		1 Yes 2			,		ecify:	Black	
003	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show uther than "natural", or Itams 23a or 28a-f show ant, it e Madical Examirar Tust Le notified at	d by	3 Widowed 4 Divorced	Year or Dates:						1-				
5	"natural"	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usual kind of work DO NOT use	k done di	uring most of w	unk orking		f Business/In 1St Fol	*	
12	withir ene. than	m.	Elementary/Secondary (0-12) 12th grade	College (1-4or N/A		1110.	00 1101 00	3 (31,100)				lowers	100	
9	filed Hygi sther ent, I	ပိ	17. Father's Name (First, Middle, Last						18. Mother's N	ame (First, Middle,				
Maryland 21215-0036	ould be Mental arked o	To Be	Bobby Ray Anders							nd Smith				
	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If liem 27 is marked other than any niqury or other traumatic event, II a M once.		19a. Informant's Name/Relationship Danielle Anders							Ru <i>ral R</i> oute Number Balto, Mo			Code)	
ore	of He of He fiter roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	1	Place of Dispo cemetery, cres	sition (Nam natory or ot	e of her place	,	Date	20c. Location	on - City or To	wn, State	
<u>Ĕ</u>	Pag ment ant: h		* 4 □ Donation 5 □ Other (Speci		K	ing Mer					Randa]	L1stown	ı, Md	
Baltimore,	permit. Depart Import any inj		21 June Juneral Service Lice	arch		22	. Name and			rch F/H sh Avenue	West	n Md (21215	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the dea	ath. Do not ent	er the mode					23 114	Approximate Interval Bety	e ween
	Pnysician		Immediate Cause (Final disease or condition	Fruis	40	t won	1101	40	the	wac			Onset and D	Death
7	/Medical		resulting in death)	a. Due to (or a	s a conse	quence of):			,					
п	Examiner		Sequentially list conditions,	b										
	₽ .≒	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or s	s a cones	quenes offe						- 2		
	and and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a		augusta of								
8760,	ate be executed thysician and the burial-transit	E		Due 10 (01 a	s a conse	iquence or).								
87	ate thy:	dicai		_ d									•	
9 X	Attending Physician: The law requires that the death certific releath. ector: After this certificate has been signed by the attending pertor: After this certificate has been signed by the attended for use as by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of prear	nancy					234	Date of delive	an/	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant	2 Fet	tal déath 3[Ectopic pre Other (spe					Month	,	'ear
P.O.	that the di ed by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				7,						
	that ned b	by Pł	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	nderlying ca	use give	n in Part I.	23e. Did to	obacco use c	ontribute to the	ne cause of d	eath?
rds	quires tha n signed uld be del	q pe								101	res 2 📉	o 3 ☐ Prob	ably 4 □U	Inknown
Vital Records,	sw requ s been 2 shoulk	Completed								24a. Was		b. Were auto	psy findings a	available
Re	The fav te has age 2	шо									rmed?	death?	2 No	ause or
ta	ician: The l certificate harector, page	0	25. Was case referred to medical						26. Place of D	eath (Check only o		~		
>	Physici this cer al direc	To B	examiner? 1 ½ Yes 2 No	Hospital:	ient 2	☐ ER/Outpatier	nt 3 DO	A Othe	. 4 Nursing	Home 5 ☐ Resid	dence 6 🗆	Other (Specif	y)	
0	ding Ph J. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D		28b. Time o Injury	28	Bc. Injury Work	at ?	28d. Describe h	now injury oc	curred		
<u>.</u> 0	ttendir death. ctor: Af y the fu	atic	2 Accident investigation	n FOUNG17	05	12:46	AM	154	es 2□No	Delga	sec .	Dero 1		
Division of	or Attence after death Director: in by the	Certification;	3 Suicide 6 Could not lead to determine	28e. Place of labuilding,	njury - At I	home, farm, sti	eet, factory,	, office		28f. Location (S City or Tox	Street and Nu vn, State)	imber or Rura	I Route Numi	ber,
Q	ital o	Cer		ļ	re	tail 5	5+0-1°	e		5447 Pa	rk Heig	hts Ane.	Balto, W	ID
	To the Hospital or Attending within 24 hours after death. To tha Funeral Director: After completely filled in by the funer	ledical		hysician: To the bes miner: On the basis	of examin)
	o the vithin 2 o tha	Med	29b. Signature and title of certifier	and manner s	stated.		29c.	License	number		29d. Date siç	gned (Month,	Day, Year)	
	F 3 F/34		> UICO	Andl	/			OCME			June	10, 20	005	
	M		30. Name and address of person who	completed cause of	death (Ite	em 23a) (Type,	Pript), ,	D -	G	D-1+2				1
	,		J, K. 1100	111					Street	Baltimo	ore, M	aryıan	u ZIZU	Т
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	1 2005	trar's Sign	nature //	19031	المنتك						

			State of Maryland / State AMEND ITEM #23PII PER PHY		rtment of He titioate/05			giene Reg. No.	05	20463
	Physici	an	1. Decedent's Name (First, Middle, Last) Alfred T. Allen				2. Date of Dea	ath 19 ^{Day}	20 ඊ 5	3. Time of Death 9:00 A. M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death			County of Death	
	Zxuiiii	٠.	Genesis Eldercare at Spa Creek		Annapo	lis		A	nne Arı	unde1
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last b</i> 230−46−2341 1⊊M 2□F 88	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Mar . 9	^h У 1 91	9. Birt	place (State or Foreign IntroCarolina
	Director		Usual Residence of Decedent							
	ryland		10a. State 10b. County 10c. City, To							10d. Inside City Limits
	8a-1 s	ecto	Maryland Anne Arundel Lintl	nicun				10a Citiza	en of What Co	1 ☐ Yes 2 ☑ No
	with t	2	10e. Street and Number		10f. Zip Code 2109	0			ted Sta	
	death me 23	nera	402 Sycamore Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. W	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-		4. Race - Amer	rican Indian,
36	or Ite	by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1007		Yes 2 No	Specify:	Tiloan, etc.,		Black, White Specify: Wh:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show the Madigal Examiner must be notified at	ed b	3 Widowed 4 Divorced Par or Dates: 1937 - 16	O II a. Decede	ent's Usual Occupa	tion			d of Business/l	
215	hin 72 a. an "na Madic	Completed	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	kind of work done du O NDT use retired)	uring most of work				,
	ed with	Сош	12 Re	etire	ed Milita				itary	
Maryland	ntel H ed ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	,		iumame)	
II Y	should nd Me mark imatic	<u>2</u>	John I. Allen 19a. Informant's Name/Relationship (Type, Print) 19	9b. Mailing	g Address (Street a		O. Joyi		Town, State, Z	ip Code)
	and 2 valith a n 27 ls er trau				ycamore R			MD	21090	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28a-4 show any futury or other traumatic event, the Marical Examener must be notified at once.		1 Devrial 2 Cremation 3 Removal from State Motor	tery, crem	sition <i>(Name of</i> natory or other place ematory	0 0110		20c. Loca	ation - City or 1	Town, State
Iţim	it. Pa ortmen ortent: njury		4 Dogation 5 Disther (Specify) 21. Signature of uneral Service Licensee		Name and Address	20	05	Cato	nsville	e, MD
Ba	Depermine Depermine Pe				irkley-Ru ZI Crain		neral Ho	gme P Burni	ė, MD 2	21061
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	c t	trythe	110				Onset and Death
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		Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Undertying Cause (Disease or injury	a of).			_			
	cate be executed physician and the burial-transit	Examiner	that initiated events c.							
60,	be exercian sician s	cal E	resulting in death) Last Due to (or as a consequence	e 01):						
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Box	The law requires that the death certificate be executed title hes been signed by the ettending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23	3d. Date of deli- Month	very Day Year
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rds,	quires tha n signed uld be del	d by	- failue 6 thrive				1 🗆 Y	′es 2□	No 3□Pro	bably 4 Dinknown
Records,	aw requir ss been si 2 should I	Completed	- ad Cedmoriusada		Accelli	2 P	24a. Was		24b. Were aut	topsy findings available ompletion of cause of
II Re		Com	ASBESTOSIS CARCINOMA COLON				perfo	rmed? 2 No	death?	2 🗆 No
Vital	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?		Otho	26. Place of Deat				
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ion	Attending r death. ector: After by the fune	atlo	2 Accident investigation	Injury		es 2 🗆 No				
27. Manner of Death Section Sect							Number or Ru	ral Route Number,		
	To the Hoapitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination a							
	o the lithin 2 o the I	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. Date	signed (Month	, Day, Year)
	H 3 H 8	/			D	5702	X	June	20, 2	005
	107		30. Name 2 d ad r ss of person who completed cause of death (item 23a	і) (Туре, Р		102				
	10		Aditya Chapra, M.D., 600 Ridgely 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ave.	, Annapol	is, Mary	land 21	401		
	Sta Registi		JUN 2 1 2005	e A	marks D					
DH	MH 17 Rev 1/2	001	The Louis Market Market	1	43.6					

ORIGINAL

Jennie Adams 05-04125 dl

	1	For State Registrar	State o	of Maryl	•	artment of Hortificate of L		-	giene Reg. No.	05	20464	
	_	. Decedent's Name (First, Middle, Las						2. Date of De		Year	3. Time of Death	
Physician /Medical	_	Jennie	Hada	ims'				June 1			9:51 P M	
Examiner	4	a. Facifity Name (If not institution, give		mber)		4b. City, Town, or		th	4c. County			
		105 Kossuth Street Social Security Number 6. Se		7 Ago /in i	vrs. last birthday)	Baltimo If Under 1 Year	re ff Under 24 Hrs	8. Date of Bir			place (State or Foreign	
Funeral Director			_M 250F	7. Age (#1)	63 Yrs.	Months Days	Hours Min		y, Year)	Cou		
	_	Isual Residence of Decedent						I lag 5	1172		· · · · · · · · · · · · · · · · · · ·	
ylan how		0a. State 10b. County		1	City, Town or Lo						10d. Inside City Limits	
or 28a-f show		Maryland NA			Baltin						1 Yes 2 No	
with the Mar s or 28e-f si be multified Director	1	0e. Street and Number	- 4 5	7	+	10f. Zip Code			10g. Citizen of	What Cou	ntry?	
sath v			12. Was Dec			Tues 1	29	Specify Ves or No	United 14 Bac	e - Ameri	can Indian,	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Health and Mental Hygiene. Health and Mental Hygiene. To Be Compieted by Funeral Director		Marital Status Mever Married 2 Married Midowed 4 □ Divorced	Armed Find Yes If Yes, Given Year or D	orces? 27 No ive		Was Decedent of His f Yes, specify Cubar I ☐ Yes 27 No	Specify:	to Rican, etc.)	Bla	ck, White,		
Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Mental Hygiene. 27 le marked other than "natural", or traumatic avent, it a Medical Evarit To Be Completed by F	-	15. Decedent's Ed	ucation			ient's Usual Occupa			16b. Kind of B	usiness/Ir	ndustry	
21215-00 ed within 72 hou ygiene. ner than "nature it, it a Medical E compieted	-	(Specify only highest grade Elementary/Secondary (0-12)		1-4or 5+)	(Give	kind of work done d OO NOT use retired)	uring most of wo	orking	Unive	2451	ty	
21 will be a wil		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4		1	egister		irse	Hosg	1+4	: 12	
ind ba file tal Hy d oth avent		7. Father's Name (First, Middle, Last)	,				18. Mother's Na	me (First, Middle	Maiden Suman 1	ne)		
Yan louid I I Meni I Me		Jesnies A	lams		401 14 15		Lyd	(a V	ones	a 7:	0.11	
Mar 12 sh h and 7 le m traum	1	19a. Informant's Name/Relationship (7	1 /	ece	19b. Mailir	g Address (Street a	1	12		State, Zij	Code)	
e, le, land 1 and Healt Healt than 2 than 2	12	Oa. Method of Disposition	9-101		b. Place of Dispo	sition (Name of	tienue	Date	20c. Location -	City or T	own, State	
Saltimore, emit. Pages 1 ar bepartment of Hea mportant: If item: my injury or other mice.		1 Burial 2 Cremation 3	Removal from	State		natory or other place		. 202m	- 1	-	MAD	
Baltimore, IM permit. Pages 1 and 2 popartment of Health Important: If item 27 i any injury or other tra page.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens		NO INCIDET		Name and Address					, , ,	
Balti permit. Departr Imports any inju	1	Laborin L. A	J. B.	-	4	FOR BOT	LIGHT	Bai	175.1M	02	-127-9	
Della della		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw.									Approximate Interval Between Onset and Death	
Pnysician /Medical		disease or condition resulting in death)	a	Attenoscievote Cardiovascular Disease								
Examiner			Due to (or as a consequence of): carted by Hyper thermia									
ةِ السَّاسَةِ ا		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying	b									
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0, 9 exa ian ar inal-t	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
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vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certific r death. actor: After this certificate has been signed by the attending t by the funeral director, page 2 should be detached for use as lification; To Be Completed by Physician/Me		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	1 Live	birth 2 ☐ F nant at time	etal death 3	Ectopic pregnancy Other (specify)			Mo	te of deliv	ery Day Year	
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rds, puires the n signeral be d		1 Yes 2 No							3 Probably 4 Unknown			
0 8 8 B	-							24a. Was autor perfo	sv I i	Were auto prior to co death?	opsy findings available impletion of cause of	
Vital F ician: Th certificate rector, pag	1 2	25. Was case referred to medical					26. Place of De	1 Yes		I JAJ THIS	2 140	
of VI hysicia his cert il direct To B		examiner? 1x☐ Yes 2☐ No	Hospital: 1 🗆	Inpatient :	2 ER/Outpatien	t 3 DOA Othe	r: 4 ☐ Nursing I	Home 5 ☐ Resid	dence 6 XIOth	er (Specii	y scene	
Division of or Attending Phyer after death. Diractor: Atter this I in by the funeral directification; To ertification; To	- 2	77. Manner of Death	28a. Date (Mor	of Injury oth, Day Yea	28b. Time of	28c. Injury Work	at ?	April -	now injury occur		D.	
endir eath. or: Af		2 Accident investigation UMCNOWN WHEN DUTY 1 Yes 2 1/No							environmenta temperatur			
Division c ltal or Attending P Its after death. The Director: After t led in by tha funera Certification;		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	280. Place	ling, etc. (Sp				28f. Location (S City or To	Street and Numb vn, State) 105	er or Rur	al Route Number, 655uTV St	
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tha Hosplin 24 hour the Funar pletely fill edical		29a. Certifier 1 ☐ Certifying Phy (Check only 2 X Medical Exam	iner: On the b			occurred at the time estigation, in my op						
o tha ithin 2 o the omple	7	29b. Signature and title of certifier	3710777	with alloward		29c. License	number		29d. Date signe	d (Month,	Day, Year)	
1		Damae HA	80 n	IA is	1 1	OCI	ΜE		June 17	. 20	05	
10	13	10. Name and address of person who c	ompleted cau	se of death (ftem 23a) (Type,	Print 111 Penr	n Street	Baltin				
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Registrar		JUN 2 1 2	005	Calebra .	gnature A	and I						

		1	For State of Maryland / Department of I	Health and M		6 U U U	20465	
Phys /Me	cian dical		Marilyn A. Brown		2. Date of Death Month	Day Year	3. Time of Death 5 05:30 AM	
Exam	niner al	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year			4c. County of Deat	hplace (State or Foreign	
Directo		10	sual Residence of Decedent la. State 10b. County 10c. City, Town or Location		8-4-1	14	10d. Inside City Limits	
to You Maryla sath with the Maryla s 23a or 28e-1 ehor	ral Director	10	1916 Dun hill Village, Apt. 102 212	.44		. Citizen of What Co		
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Iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours aft to Health and Mental Hygiene. If item 27 te marked other then "neturelt, or or other treumatic event, the Medical Example."	Completed			during most of working	ϱ	h. Kind of Business/l	orp.	
faryland 212: 2 should be filed within and Menta Hygiene. le marked other then eumatic event, the M.	To Be	(Father's Name (First, Middle, Last) James Brown Da. Informant's Name/Relationship (Type Print) 19b. Mailin, Address (Street	18. Mother's Name Evely	n Di	Hard	-0-4	
ore, Ma s 1 and 2 of Health a filem 27 le		1	enise Bur ton Daughter 7916 Duni 1 a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State	1 Village	#102 B	ilto, MI	21244 Town, State	
Timer rither views	X	2	Loubn Park	6/2	2/05 p	Baltimo e Service		
S8760, Character be executed hysician and physician and physician and sthe burial-transit	dicai Examiner	In di re	ia. Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. Immediate Cause (Final sease or condition sulting in death) a. Light Gancer (metal pue to (or as a consequence of): Acute remainded to immediate use. Enter Underlying use. Enter Underlying use. Enter Underlying sultinitiated events sulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	ng, such as cardiac on	r respiratory arrest,	<i>933</i> (• <i>40</i>) 1)	Approximate Interval Between Onset and Death & Months 2 days	
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n of ng Phye	Certification; To B	27.	3 Suiside 6 Could not be	er: 4 Nursing Hom	, , , , , ,	6 □Other (Specification)	y)	
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To the Howithin 24 h	Medical		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated. 2 Signature and title of certifier 29c. License	pinion, death occurred	at the time, date a	o(s) and manner as s and place, and due to Date signed (Month,	the cause(s)	
		30.	I thame kenton, MD pos	5-000			re 18,2005	
	ate	_	Millianne Kenton, MD Sina Hispitz	al of Bai	itimore			
Regis	_		JUN 2 1 2005					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** DAVID 17 JEFFREY JUNE 0744 Ам /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BELAIR HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 1984 9. Birthplace (State or Foreign Country) **Funeral** 6 Sex 7. Age (In yrs. last birthday) **†**ØM 2□ F Director 137 88 4949 Usual Residence of Decedent filad within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location th and Mental Hygiene. 7 Ie markad other than "naturel", or Itams 23a or 28e-1 shov treumatic event, the Madical Examinar must be notified at 28e-1 show 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No ODELBATT HARFOR 17 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1418 BA Funeral 41016 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 250 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No by 3 Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 18b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Y RS UNDERGROUND LIPPISAIL SLECTRIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should ba I nent of Health and Mental I (----B5.1 ٥ LIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1418 BENZIE item 27 other t MR+MRS DEVIOLE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oc. Location · City or Town, State Date f)⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State JUNE 23 = 5 Department of Important: If eny injury of once. 4 □ Donation 5 □ Other (Specify) DARLINGTON LEMENT 22. Name and Address of Facility 21. Sign fure of Fun ral Service Licensee 3 NEW ACRT DRIVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE DIYURUS Priysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 (9 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\sqrt{No} \) certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred s after dee.
**el Diractor: After 6-17-08 Approx 6:48 1 Natural 5 Pending 1 Yes 2 No DELVONOFCAR IMPAGUITALAR 2 Accident investigation 6 Could not be determined 3 Duicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide FODDWAY To the Hospitel within 24 hours a To the Funerel D 543 HARFORD GO 27 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME Sull 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNE 18, 2005 MARYSOUTS A KORFU 111 Penn Street Baltimore, Maryland 21201

State Registrar Special states

32. Registrar's Signature

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

State of Maryland / Department of Health and Mental Hygiene 20467 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June **Physician** 18, Rosalie 2005 /Medical 1:10pm M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 692 Scottsdale Road Westminster Carroll 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Jan 22, 1 Birthplace (State or Foreign Country)
 MD 1□M 2□ F Director 220-12-6365 79 Yrs Jan Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar yest be notified at MD Carroll Westminster Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 692 Scottsdale Road or items 23a 21157 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If item 27 Is marked other then "naturel", or itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Liberto Catherine Graziano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John C. Baer, Jr. (Son) 1308 Green Pond Court Westminster, MD 21157 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 8 pernit. Page Department o Importent: If any njury or once. Lake View Mem. Park 6/22/05 Sykesville, MD 21. Signature of Funeral Service License HAIGHT FUNERAL HOME & CHAPEL (PO Box 195) Blean o Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Privsician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** PULMONARY OBSTRUCTIVE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760. as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) the be detached 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 → Yes 2 □ No funeral director, page 2 should Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending after death. death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 296. Signature) and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) , pr WIR Druco June 20, 2005 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) Ellis 1645 Eldershiry LIBEVA State Registrar

		•	For State	State of Maryland /	Department of H		((UU)	20468	
			Registrer 1. Decedent's Name (First, Middle, Last)	21	- t			Reg. No. 2. Date of Death Month Day Year		
	Physici /Medic		ILSE	BIMBA			JUDE 1	9:05 M		
	Examin	er	4a. Facility Name (If not institution, give s MARINER H	treet and number)	4b. City, Town, o	ROADI	E	Ic. County of Death	8	
	Funeral Director		5. Social Security Number 6. Sex	M 2XF 7. Age (In yrs. last t	oirthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth Month, Day, Yea	9. Birth	place (State or Foreign	
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	Marylar -{ show ied at	tor	10a. State 10b. County A A	(26) (3/L)	wn or Location FN BIN	NIE			10d. Inside City Limits 1 Yes 2 □ No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, the Medical Examenation and Da notified at	Funeral Director	10e. Street and Number	a d a Ta	AD: 10f. Zip Code	66-	10g. (Citizen of What Cou	untry?	
	ms 23a	erai	1355 FORW	2. Was Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spec	ify Yes or No-	14. Race - Amer		
36	s after o	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuba	Specify:	can, etc.)	Black, White	, etc.	
215-0036	72 hour seturel	ted b	15. Decedent's Educ (Specify only highest grade	Year or Dates:	a. Decedent's Usual Occup	ation	16b.	Kind of Business/I	HI / C	
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	e filed with al Hygiene. other ther vent, the N	Be Co	17. Father's Name (First, Middle, Last)	~	HOMEMI	18. Mother's Name	First, Middle, Maide	en Sumame)	4716	
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Mai	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship (Type)	1KrSch	9b. Mailing Address (Street	and Number of Hurai	TELL G	FI	21060	
ore,	iges 1 and 2 and 21 if item 27 or other tree		20a. Method of Disposition 1 Burial 2 Cremation 3 R	ceme	of Disposition (Name of tery, crematory or other place	(a) TULE	te/17 20c.	Location - City or 1	own, State	
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Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28	Bf. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,	
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	the Ho hin 24 the Fu npletel	Medical	one)	er: On the basis of examination and manner stated.	and/or investigation, in my o			and place, and due Date signed (Month		
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	7		1/4/2 11	mpleted cause of death (Item 23a	a) (Type, Print)	7569 reene Tr	0-1	6/16/0	, P	
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			For State Registrar	State of Maryland /	Certificate of Death	Reg. I	2000 20400
	Physici	an	1. Decedent's Name (First, Middle, La		1 ***		Day Year
	/Medic	cal	4a. Facility Name (If not institution, gi	F.X. BUA	4b. City, Town, or Location of Dea		2005 8:42 P M 4c. County of Death
	Examir	ier	2522 WILKENS AVE	o street and rismosty	BALTIMORE CITY		W/A
2	Funeral Director		5. Social Security Number 6.	Sex. 7. Age (In yrs. last I		s. 8. Date of Birth	9. Birthplace (State or Foreign Country)
,	aryland show	_	10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
	ith the Marylan or 28e-f show	Director	10e. Street and Number	DAL	10f. Zip Code	100.0	Citizen of What Country?
	h with	ai Dir	2522 UliM	KENS AVE.	21223		U.5.A.
9	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or items 23e or 28e-f show svent, the Medical Examinar must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Acmed Forces? 1 X Yes 2 □ No WYes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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	filed with Hygiene. ther thei	Cor	17. Father's Name (First, Middle, Las	t)	18. Mother's No	ame (First, Middle, Maid	PODUCE (en Sumame)
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Maryland	d 2 should th and Men 7 Is marke treumetic	ľ	19a. Informant's Name/Relationship	(Type, Print) 19	9b. Mailing Address (Street and Number or I	Rural Route Number, Cit	ry or Town, State, Zip Code)
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then any rigury or other treumetic avent. Ite Managnes.		20a. Method of Disposition	come	of Disposition (Name of tery, crematory or other place)	Date 17 20c.	Location - City or Town, State
altimore,	permit. Page Department of Importent: If any injury or once.		`4 Decation 5 Other (Spec	9/11	VIEW CREM.	seet B	SETIMBRE MD.
Ba	Depar Impor any ir once.		21. Signature of Funeral Service Lice	Sparle n.	22. Name and Address of Eacility	28 29 HU	1501 ST M15-21234
	- 10		shock, or heart failure. List only	nplications that caused the death. D	o not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Acute Alcohol In			
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	that the death cer ed by the attendir detached for use	by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day Year
s, P.O	res that thighed by	y Ph	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ord	w require been sig should b					-	2 No 3 Probably 4 Unknown
Vital Records,	2 2 2	Completed				24a. Was an autopsy performed'	
Vita	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/0	Othor	eath <i>(Check only one)</i> Home 5 Residence	6♥Other (Specify) SCENE
n of	ding Phys n. After this funeral di	on: To	1 X Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1,	ime of 28c. Injury at	28d. Describe how in	- 21
Division	ttendir death. stor: Al	icatic	2 Accident investigation 3 Suicide 6 Could not	on 6/11/2005	8:40 P M 1 Yes 2 ANO	unk 28f. Location (Street	and Number or Rural Route Number,
Div	s after of Direct	Certification:	4 Homicide determine	28e. Place of Injury - At home, building etc. (Specify)	nce	Baltimore,	ate) 2522 Wilkens Avenue
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 ☐ Certifying F (Check only one) 1 ☐ Certifying F 2 ☑ Medical Exa	Physicien: To the best of my knowled Iminer: On the basis of examination and and manner stated.	ige, death occurred at the time, date and place and/or investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	A 4 -	29c. License number		Date signed (Month, Day, Year)
			Culvill	elle Al	OCME	J	UNE 12, 2005
			30. Name and address of person who	completed cause of death (Item 23a	111 Penn Stree	t Baltimor	re, Maryland 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	parte		

			For State Registrar		Marylan	d / Depa		t of H	ealth a	and M	_	giene 2	005	20470
	. Dhysisi		1. Decedent's Name (First, Middle, Last,								2. Date of De Month	eath Day	Year	3. Time of Death
	 Physicia /Medic 		Amelia Maxine Bir								06	18	2005	12:55 PM
	Examin	er	4a. Facility Name (If not institution, give		//.	k0			Location of		v	4c. Cour	nty of Death n/a	
	- ·		Sinai Hospital 5. Social Security Number 6. Sec		7. Age (In yrs.)				10 YE		8. Date of Bi (Month, D	rth		place (State or Foreign
	Funeral Director		214–38–2562]M 2⊠F	65	Yrs.	Months	Days	Hours	Min.	May 17	, 1940		yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	within 72 hours after death with the Maryland ene. han "natural", or items 23s or 28s-f show 're Madical Examitmet" and be notified at	ctor	Maryland Baltimon	re	Ca	tonsvi	lle							1 ☐ Yes 2 No
1	with the sor 26	Funeral Director	10e. Street and Number 7204 Inwood Avenue	ž			10f. Zip		21228			10g. Citizen o	f What Cou ed Sta	·
te	death	nera		12. Was Dece	dent Ever in U.	S. 13.	Was Deced			gin? (Spe	cify Yes or N Rican, etc.)		ace - Americ	can Indian,
3; Kett	after or ite	/ Fur	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Give	2 X No		1 Tes, spec				rican, etc.)	Spec	lack, White,	hite
K S	hours tural',	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Da	ites:	162 Deco	dent's Usua	al Occup	ation			16b. Kind of		
6 5	n nai	Completed	(Specify only highest grad	e completed)	Aor Eu)	(Give	kind of wor DO NOT us	rk done d se retired	during mos	t of workii	ng	Tab. King of	Dusillessyll	dustry
212	d with giene er tha	Com	Elementary/Secondary (0-12)	College (1-	401 5+)	Home	emaker	:				Own	Home	
Amelia Maxine Bir Bultimore. Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insportant of Health and Mental Hygione. Insportant of Health and Mental Hygione insportant: If time 27 is marked other than "natural; or liems 23a or 28a-f show any injury or other treumatic svent. It's Madical Examinations used by notified at once.	To Be C	17. Father's Name (First, Middle, Last) Strauther Fletcher	Daile	Y							a, Maiden Sum Baranows		
ary /	2 shou and M is mar	-	19a. Informant's Name/Relationship (T)	_	-		_					er, City or Tow		
melia	1 and Health tem 27		Thomas H. Birkett 20a. Method of Disposition	/ Husba		/204 lace of Dispo emetery, crei					itonsvi ate	.11e Ma 20c. Location		d 21228 own, State
W low	Pages ent of nt: if it		1 Burial 2 Cremation 3 F							6/23/	' 05	Marriot	tsvil	le, MD
Balti	permit. Departm Importer any inju		1. Signature of Funeral Service Licens		Den	22	2. Name an	d Addres	s of Facilit	y Huk	bard F	uneral	Home,	·
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cane cause on ea	sused the death								Î	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Bila	tera/	Ten.					,			Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	dione	uence of):		0						Chour
	/n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (oras a c sequ		ricei	- 4	PIC	, .				<i>© 700 00 0</i>
l	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	or as a consequ	uence of):							-	
760.	ate be executed hysician and he burial-transit	caiE		d										
68	rtificati ng phy as the		IF FEMALE:											
Вох	ath ce attendii	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	come of pregna	Idéath 3[□Ectopic pr					I	Date of delive Month	ery Day Year
o	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	ant at time of down	eam or	Other (sp	еспу)						
c, G	s that gned t	by P	Part II. Other significant conditions co	/		_		-	en in Part I					he cause of death?
ord	w requires (been signers)	eted	Mitval Val Coronary	ve v	2 gar	gical	TION					Yes 2 No		oably 4 ∐Unknown
Rec	he law e has t ige 2 s	Completed	Renal fai		44 a1	seas	0.					ormed?	prior to co death?	opsy findings available impletion of cause of
<u>e</u>	sicion: The lav certificate has rector, page 2	Be Co	25. Was case referred to medical	lure					26. Place	of Death	(Check only	212 No	1 🗆 Yes	2 No
<u> </u>	Physici this cer al direc	To B	examiner? 1 Tes 2 No	Hospital: 1 🕱 Ir	npatient 2	EP/Outpatier	nt 3 DC	Oth	өг: 4 <u>П</u> Nu	rsing Hor	ne 5 Res	idence 6 🗆 C	ther (Specia	5⁄)
Division of Vital Records, P.O. Box	ding Pt h. After th	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time o Injury	of 2	8c. Injury Worl	yat k? Yes 2 □	2		how injury occ		
isio	Attsno death octor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At hogg, etc. (Specif	ome, farm, st			163 2	-			nber or Run	al Route Number,
į	ital or its after all Dire	Certi	4 Hollicide	i i								wn, State)		
	To the Hospital or Attsnding Physicien: The law requires that the death certifica within 24 hours after death certificate within 124 hours after death continued to the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certification: To	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the ner: On the ba and mann	isis of examina	wledge, deat tion and/or in	h occurred ivestigation	at the tin , in my o	ne, date an pinion, dea	nd place, a th occurre	and due to the ed at the time	cause(s) and i , date and place	manner as s e, and due t	stated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	\supset	4/	λ			e number			29d. Date sign		
			11/1	9/	u M.				247			Vane	-18	- 2005
	6		30. Name and address of person who of Alciandro SEQUE	mpleted cause	e of death (Item	1 23a) (Type,	Print)	11100	+ B_1	va D-	re Rol	timore	Mal	2/2/5
	Sta		31. Date filed (Month, Day, Year)	32. H	egistrar's Signa	ture	- 401	w 4J	- 1	-46	·······································	2:-/01	. 19	~10/_
	Registi	ar	JUN 2 1 20	05	Sug.	KA	and.							

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of	Maryland		artment tificate					Reg. No.	400	5	20	471
ı	Physici	an	Decedent's Name (First, Middle, La ROBERT JAM		RANDENBU	n.c					2. Oate of D Month JUNE	eath 18	200	ar	-	of Death
	/Medio		ROBERT JAM 4a. Facility Name (If not institution, gir			N.G	4b. City.	Fown. or	Location of	of Death	JUNE		County of [0:55	5 A M
	Examin	ier	CHESAPEAKE HOS					THIC					ANNE		NDEL	
	Funeral		,	Sex 7 1 ☑ M 2 ☐ F	. Age (In yrs. last		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of B	rth ay, Year)	9.	Birthp Coun	ace (State	or Foreign
	Director		218-03-8563 Usual Residence of Decedent	M Z	87	Yrs.					08/07	/1917	7		MI)
	yland Iow		10a. State 10b. County		10c. City, T	own or Lo	cation							10	0d. Inside	City Limits
	e Mar	ctor	MD ANNE AR	UNDEL	LIN	THICU	IM								1 🗌 Ye	s 2 XNo
	or 28	Dire	10e. Street and Number				10f. Zip					10g. Citi	izen of Wha		try?	
	eath v	erai	432 HAWTHORNE RO		ent Ever in U.S.	13 \		1090		nin? (Spec	rify Yes or N	0.	US 14. Race - /		an Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exambrat must be inclined at once.	by Funeral Director	1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? XNo		fYes, spec I ☐ Yes 2		Specify:	, Puerto F	cify Yes or N lican, etc.)		Black, V Specify:	Vhite, e	etc.	
5-0	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gr		1	6a. Deced	lent's Usua kind of wor DO NDT us	l Occupa k done di	tion uring most	of workin	g	16b. Ki	nd of Busin	ess/Ind	lustry	
121	within ene.	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	MANA		e retired)				CON	SUMER	DD	ODIICI	r.c
d 2	e filed within al Hygiene. I other than "vent, I'vent, I'venten weithen weithen"	e Co	17. Father's Name (First, Middle, Las	t)		PIANA	GEN		18. Mothe	r's Name	(First, Middle			PK	ODUCI	LO
'lan	ould be Mental warked o	To Be	LAWRENCE BRANDER	NBURG					MAR	Y ELI	EN REI	ESE				
Maryland	2 should be and Mental is marked aumatic ev		19a. Informant's Name/Relationship				•				Route Numi				Code)	
	1 and Heelth Sm 27 ther tr		MRS. DELMA BRAND	ENBURG /			AWTHO sition (Nam		ROAD	, LIN	THICU		210 cation - City		wn State	
nor	ages int of h t: if ite		1 ☐ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special		ate ceme	etery, cren	natory or ot N MEM	her place		6/21/						
Baltimore,	permit. Pages 1 and 2 Department of Heelih a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral Service Lice		MO141	22	. Name and	d Address	s of Facilit	y SIN	GLETON	I FUN		HOM	E	
			23a. Part1. Enter the disease, or con	nplications that car	ised the death. [GLEN respiratory a		ILE, II	<u>U</u>	21061 Approxima Interval Be	ate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition		RKIN	100	· ·		0	() 3	rn—e	13			Onset and	
	/Medical Examiner		resulting in death)	Due to (o	as a consequen	ce of):	,		0 / 1		4/3				707	721
ŀ.	Examine:	Je.	Sequentially list conditions,	b. Due to (a	as a consequen	os off.					***				_	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c												
Ó,	cate be executed obly sicien and the burial-transit		resulting in death) Last		as a consequen	ce of):										
8760,	cate b physic the ba	dica		_ d										-		
Box 6	death certifica e attending phy d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								1 2	23d. Date of	deliver	v	
P.O. B		Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Fetal dea nt at time of death n		Ectopic pre Other (spe						Month	ı	Day	Year
	taw requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to dea	th but not resultin	g in the ur	derlying ca	use givei	n in Part I.		23e. Did	tobacco u	se contribut	e to the	e cause of	death?
ords	w requires that been signed b should be det	ted t									1 🗆	Yes 2	3No 3□] Proba	ably 4]Unknown
of Vital Records,	e taw re has be je 2 sho	Completed									24a. Was	psy	prior	to corr	sy findings	s available cause of
<u>س</u>	Th ete pag										1 Yes	ormed?	deat		2□ No	
Σ.	Physician: Th r this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 NO	Hospital: 1 ☐ Ing		Outpatien	0000				<i>(Check only</i> e 5 □ Res		X7380		HOCD	TOE
o	g Phys er this eral di	 	27. Manner of Death	28a. Date of		b. Time of Injury		c. Injury Work	at		e 5 🗆 Hes 3d. Describe			<i>ъресіту,</i>	позр	TUE
ion	Attending Indeath.	atio	1 Anatural 5 Pending 2 Accident investigation	n	Day rear)	пцигу	М		es 2 🗆 l	No						
Division	for Attendations of the formula of the formula of the formula of the fin by the	Certification:	3 Suicide 6 Could not to determined	286. Place 0	Injury - At home, , etc. <i>(Specify)</i>	, farm, stre	eet, factory,	office		28	3f. Location (City or To	Street and wn, State)	d Number o	r Rural	Route Nui	mber,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examination	dge, death and/or inv	occurred a	t the time	e, date and inion, deat	d place, ar	nd due to the	cause(s) date and	and manne place, and	r as sta due to	ited. the cause	(s)
	To the within To the Somple	Med	29b. Signature and title of penifier	and maile				License					e signed (M			
			I the se	_			0	クン	839	5		JUN	117	20)	20	US
	(1)		30. Name and address of person who	completed cause	of death (Item 23	a) (Type,	Print)	ינמי	126	2 .	LIN	157		2-1	091	2
	Sta R egistr		31. Date filed (Month, Day, Year) JUN 2 1 200	32. Rec	istrar's Signature	1				-			,			
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DHMH 17 Rev 1/2001

	1- State Unpend Item 23a,27,28a-f per me Registrar	G845 7-13-05 tas irtificate of Death	Reg.	2005 20472 No.
Dhysisian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
Physician /Medical	CAROLYN RUTH BONER		JUNE 11,	2005 11:27 A ^M
Examiner	4a. Facility Name (If not institution, give street and number) 525 KINTOP RD	4b. City, Town, or Location of Death		4c. County of Death ANNE ARUNDEL CO
uneral Director	5. Social Security Number 214-48-2302 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 52 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. 5/14/194	9. Birthplace (State or Foreign Country) MD
>-:::	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
a, or tems 23a of 28a-r anow Exart at frust be retified at by Funeral Director	10a. State 10b. County 10c. City, Town or U MD ANNE ARUNDEL GLEN BUR			1 Tyes 2 Tho
te nutified Director			100	Citizen of What Country?
Dir.	10e. Street and Number 525 KINTOP ROAD	10f. Zip Code 21061		
erai				U.S.A.
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc. Specify: WHITE
		edent's Usual Occupation		Kind of Business/Industry
Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	King	
Š		EMAKER	O1	WN HOME
Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	len Surname)
10	ALLEN FRANCIS KNIGHT, SR.	MARY MA	RTHA ISABE	L JIMENEZ
<u>.</u>	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip Code)
	DAWN AXTELL - DAUGHTER 525	MANOR ROAD, GLEN	BURNIE, MD	21061
	20a. Method of Dispesition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of ematory or other place)	Date 20c.	Location - City or Town, State
	*4 Donation 5 Other (Specify) CHESAPEA	KE CREMATION 6/18	8/2005 ST	EVENSVILLE, MD
once. To	21. Signature of European Service Libensee	22. Name and Address of Facility	INGLETON F	UNERAL HOME P.A.
a	the Whale mo1120 1	SECOND AVE. S.W.	, GLEN BURN	NIE, MD 21061
the buriat-transit acidical Examiner	In rediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Gunshot Wound of Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	Head		
Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Completed			24a. Was an autopsy performed	
a	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
To B	examiner? 1 XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ome 5 Residence	6 Other (Specify) SCENE
	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury 28b. Time Formed 7. Day Year) Found 11:25	of 28c. Injury at Work?	28d. Describe how in	jury occurred
atio	1 Natural 5 Pending Found, Day Year) 1:25	AM 1 ☐ Yes 2 XNo	Subject sl	not
Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify) Found at home	treet, factory, office	28f. Location (Street City or Town, Sta Glen Burn	and Number or Rural Route Number, ate) 525 Kintop Rd. ie, Md
Medical Certific	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal (Check only one) 2 Medicel Examiner: On the basis of examination and/or in and manner stated.			
×	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
	30_Name and address of person who completed cause of death, (Item 23a) (Type	OCME OCME	1	UNE 12, 2005
	30 Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year)	111 Penn Street	t Baltimor	ce, Maryland 21201
State egistrar	JUN 2 1 2005	de		

)			State of Maryland / Department of Health and state Unpend Item 23a,27,28a-f per me G845,7-14-05 tas	d Men	ntal Hygi	ene ()	05	20473
			1. Decedent's Name (First, Middle, Last)		Date of Death			3. Time of Death
	Physici		ROBERT NEIL BONER		Month JUNE	Day	Year 2005	11:55A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec	eath	JUNE		ty of Death	
	LXamii	C.	NORTH ARUNDEL HOSPITAL GLEN BURNIE			ANNE	ARUND	ET.
DC	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi	Hrs. 8. [Date of Birth Month, Day,		9. Birth	place (State or Foreign ntry)
Q	Director		219-40-0214	11n. 2	4/22/19	Year) 943	MD	ritry)
4	p ,		Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County 10c. City, Town or Location					10d Inside City Limits
	arylan show	_						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the M. 28e-f	Director					()411) 6	
	with t		10e. Street and Number 10f. Zip Code		10	g. Cítizen o		ntry?
	within 72 hours after death with the Maryland ena. than "natural", or Items 23a or 28e-f show Its Modical Examiner must be mailind at	Funeral	525 KINTOP ROAD 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	/Specify	Vas or No-	U.S.A	ace - Ameri	can Indian
	Item Inerr	ņ	Armed Forces? If Yes, specify Cuban, Mexican, Pue	ierto Rica	in, etc.)		ack, White	etc.
36	irs aff	by F	1 ☐ Yes ZE No Specity: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Spec	ify: WE	ITE
5-0036	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation		1	6b. Kind of	Business/Ir	ndustry
215	d within 72 ho piena. r than "natu	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of wife. DO NOT use retired)	working				
2121	77 77 -	Completed	12 SUPERVISOR			PLAST	CICS	
	m = 0 5	Be (17. Father's Name (First, Middle, Last) 18. Mother's N	Name (Fir	rst, Middle, M	laiden Suma	ame)	
<u> a</u>	should by nd Menta marked rmaric av	2	BERNICE BLANE BONER EDNA	MAY	DRAIN			
Maryland	S S S		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I			•		o Code)
_	Health tem 27		DAWN AXTELL - DAUGHTER 525 MANOR ROAD, GLEN		RNIE, N	1D 210	61	
Baltimore,	parmit. Pages 1 a Department of Hee Important: If Item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	2	Oc. Location	r - City or T	own, State
Ĕ	Pag ment ant: I		`4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 6/	/18/2	2005	STEVEN	SVILL	E, MD
alt	pparti		21. Signature 15 al 3 ervice Licensee 22. Name and Address of Facility	SING	SLETON	FUNER	AL HO	ME P.A.
<u>m</u>	20 E 2 9	2. 4	1 SECOND AVE. S.W	V., C	ELEN BU	JRNIE,	MD 2	1061
			23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	diac or res	spiratory arre	st,		Approximate Interval Between
	Pnysician	0.4	Immediate Cause (Final Classe or condition Gunshot Wound of Chest					Onset and Death
7	/Medical		Tes ulting in death) Due to (or as a consequence of):					
- 10	Examiner		Sequentially list conditions.					
	ed isi	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	and -tran	cam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				-	
760,	be axecute sician and burial-trans		bue to (or as a consequence or).					
687	를 찾으	dical	d	 				
9 ×	leath cartifica attending ph d for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			034 5	ate of deli-	
Вох	atten for us	lan	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy				ate of deliv fonth	ery Day Year
o.	by the datached	yslc	1 Yes 2 No 9 Unknown 9 Unknown					
P.0	res that the signed by be detacted		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did toba	acco use co	ntribute to t	he cause of death?
ds,	uires sign d be	d by			1 🗆 Yes	s No	3 🗌 Pro	bably 4 Unknown
Ö	v requ	ete			24a. Was an	246	Word aut	opsy findings available
3e	has has	ompleted		-	autopsy		prior to co death?	empletion of cause of
<u>=</u>	icien: The certificate ha rector, page	O	OF Western stand to modified		Yes 2	□No	1 Yes	2□ No
of Vital Records,	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? 1X Yes 2 No Hospital: 1 Inpatient 2 X EP/Outpatient 3 DOA Other: 4 Nursing					
of	Phys rthis raldi	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		5 Resider			(y)
on	iding F th. After funera	tlor	investigation Pound 1 Yes 2 YNo	Su	bject	shot s	self	
Division	Attendi death. ctor: A y the fu	Certification;	3 Suicide 6 Could not be determined determined	_				al Route Number,
Ο̈́	after after Dire	ert	4 ☐ Homicide building, etc. (Specify) Found at home		City or Town, en Bur	_		ntop Ka.
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plan	ace, and	due to the car	use(s) and n	nanner as s	stated.
	e Ho 24 h e Fui letely	Medical	(Check only one) 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	ccurred a	t the time, da	te and place	, and due t	o the cause(s)
_	Fo th Within Fo th	Me	29b. Signature and title of certified 29c. License number		29	d. Date sign	ed (Month,	Day, Year)
			Hote : Opmica - Lalle and OCME		п	INE 12	200	5
		1	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)					
			Patercia Sconica - Pollak MD 111 Penn Stree	et E	Ba⊥timo	ore, M	aryla	nd 21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	ar	HIN 2 1 2005 Beauty St. Aprile					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	tate of Maryland /		ment of Hea <i>ficate of De</i>		ntal Hygien Reg. N	211115	20474
Physicia		Decedent's Name (First, Middle, Last)	da E. Bry1			2.	Date of Death Month	ay Hy Year ZVOS	3. Time of Death
/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give streen for the facility Name (If not institution, give streen for the facility Number for the facility Num	et and nymber) 1	birthday)		Burr		C. County of Death	Polace (State or Foreign try)
ס		Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Locati	00				10d. Inside City Limits
Maryla f shov	ō	Maryland Anne Arur		1timor					1 ☐ Yes 2 🖾 No
h with the 23a or 28e-	Direc	10e. Street and Number 5712 Moore Stree			10f. Zip Code 2122	5	10g. C	Citizen of What Cou	ntry?
be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Items 23a or 28e-f show event, If a Marical Examination of the natified at	by Funerai	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (A)No If Yes, Give Year or Dates:	1	Decedent of Hispar es, specify Cuban, M Yes 2 🔀 No Sp	nic Origin? (Specify lexican, Puerto Rica pecify:	Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: White	etc.
within 72 ho ene. than "natur i e Modical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)		6a. Decedent (Give kind life. DO Clerk	's Usual Occupation d of work done durin NOT use retired)	n Ig most of working		Kind of Business/In	dustry Cleaners
should be filed and Mental Hygis marked other matic event,	To Be Co	17. Father's Name (First, Middle, Last)	August Sautt	er	18.	Mother's Name (Fi	irst, Middle, Maide Albers	en Sumame)	- M
d 2 s th ar 7 is trau		19a. Informant's Name/Relationship (Type, Walter Bryl / Hust			oore Street			or Town, State, Zip Maryland	
of He		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Rem	oval from State ceme	-	ory or other place)	Date	_	Location - City or To $1 exttt{timore}$,	
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	- HOLY	1. 22. N	S Cemetery ame and Address of 31 Ritchie	Facility Gon	ce Funer	al Servic	
Physician // Medical Examiner st the burial-transit	edicai Examiner	23. Part1. Enter the disease, shock, or heart failure. List only one shock, or heart failure. List only one shock or heart failure. List only one shock of the sh	Due to (or as a consequent) Due to (or as a consequent) Due to (or as a consequent)	ice of):	he mode of dying, su A r ter	y d my s fus solution as cardiac or re	0.	çe	Approximate Interval Between Onset and Death
The law requires that the death certific site has been signed by the attending p bage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2*5 No 9 □ Unknown	If yes, outcome of pregnancy Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 □Ec	topic pregnancy ther (specify)			23d. Date of deliv Month	ery Day Year
quires that n signed by uld be deta	by	Part II. Other significant conditions contri	outing to death but not resultin	ng in the unde	rlying cause given in	Part I.		use contribute to t	he cause of death? pably 4 Unknown
	Completed						24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
ician certifis	Be	25. Was case referred to medical examiner?	pital:		Othor	. Place of Death (C			
ng Phys (fter this uneral of	ation: To	TIL Tes ZAZINO	ryinpatient 2 ER	Outpatient Bb. Time of Injury	28c. Injury at Work?		5 Residence Describe how inj	6 ☐Other (Special iury occurred	(y)
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	a Could not be	28e. Place of Injury - At home building, etc. (Specify)	a, farm, street	factory, office	28f.	Location (Street a City or Town, Sta	and Number or Run te)	al Route Number,
e Hospit 24 hour e Funers etely fille	Medical (an: To the best of my knowle On the basis of examination and manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier	mD		29c. License nu	mber 206	29d. D	Date signed (Month,	Day, Year)
O		30. Name and address of person who com	TEY, 3	0	Hospi	tal b	v./ 671	in Bu	July my
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Soul	٠		1		

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar	nd / Depa	artme		Ith and I	Mental Hy	giene Reg. No.	2005	2.01.7
	Physici /Medic Examin	al	BOBY BOY 4a. Facility Name (If not institution, give	1 4 . 1 .		4b. Ci	ly, Town, or Loc		JUNE	11Day	ounty of Death	2130 M
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director	24	5. Social Security Number (INL 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Unc		Under 24 Hrs. ours Min.	8. Date of Bin (Month, Da	th Year)	9. Birthp Cour	lace (State or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	į	ty, Town or Lo						1	0d. Inside City Limits 1 Yes 2 □ No
	ath with the	ral Director	10e. Street and Number 2946 AREN.	AH AVE		10f.	Zip Code 12 16				on of What Cour	L'
980	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Jical Evan Avermina Le modified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:				nic Origin? (S) exican, Puerto pecify:	pecify Yes or No o Rican, etc.)		. Race - Americ Black, White, pecify: B / A	
21215-0036	within ene. then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	kind of	sual Occupation work done durin use retired)	g most of wor	king	16b. Kind	of Business/Ind	dustry
Maryland 2	should be filed and Mental Hygis s marked other umatic svent, II	To Be C	17. Father's Name (First, Middle, Last) DAMÓN		RTER		T	ERA	ne (First, Middle,		BA	Cou W
	nd 2 salth ar 27 is 27 is r trau		19a. Informant's Name/Relationship (Ty DAMON CARTER 20a. Method of Disposition	FATHER 20b. 1	19b. Mailir 294 Place of Disponentery, crer	6 1	AREN	4 4 3	PAVE B	Alto 1	tion - City or To	-1216
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Wo	odlawn	Cer	netery		/2005 to chwab Funue; Cat		awn, Ma l Home,	
	Physician /Medical Examiner e pariar-transit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infjury that initiated events resulting in death) Last	ne cause on each line.	quence of):		ode of dying, su			rrest,		Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic Other	pregnancy (specify)			230	d. Date of delive Month	ry Oay Year
o, O	w requires that been signed by should be deta	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlyin	g cause given in	Part I.	23e. Did to		/	e cause of death?
of Vital Record		Completed							24a. Was autor perfo 1 Yes		prior to cor death?	osy findings available inpletion of cause of
Ë	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	1		Othor		th (Check only o	•		
	Phys raidi	tlon; To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injury at Work?		ome 5 Resident			/)
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At h building, etc. (Special	ome, farm, str	eet, fact	ory, office		28f. Location (S City or Tox	Street and I vn, State)	Number or Rura	l Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier Certifying Physical Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deatl ation and/or in	h occurr vestigati	ed at the time, d on, in my opinio	ate and place n, death occu	, and due to the rred at the time,	cause(s) ar date and pl	nd manner as st lace, and due to	ated. the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	n nu		1	29c. License nur	nber			signed (Month, i	
			30, Name and address of person who co	nis 301	St.	Print)	u Pla	ice	·			
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature							

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ORIGINAL

			1 = For State Registrar	State of	Maryland		artmen rtificate			nd M		giene 2	005	20476			
	2		1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea	ath Day	Year	3. Time of Death			
	Physici /Medic		VERONICA			Bu	TZ				June	17	200	7:30 PM			
	Examin		4a. Fecility Name (If not institution, gi	ve street and numb	oer)			Town, or	Location of	Death		4c. Cou	nty of Death	3. Time of Death 7.30 P M ath Introduce (State or Foreign Fountry) 10d. Inside City Limits 1 Yes 2 No Fountry? ates Foreign Fountry? ates Foreign Fountry? ates Foreign Fountry? In Yes 2 No Fountry? Ates Foreign Foreign Fountry? Foreign Fore			
			1303 Marquis Ct.						Falls	ton		Har	ford				
	Funeral				Age (In yrs. las		If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birti (Month, Da)	h v, Year)	9. Birth	place (State or Foreign ntry)			
	Director		214.48.0139	1 M 2 VF	58	Yrs.						1/1946	MD				
	D >		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation							10d Inside City Limits			
	show	٦					Cation										
	89-f	ecto	MD Harfor	α	ra1.	lston	1	0.1				10a China	-4.14/5-21.00				
	Vith E	Director	10e. Street and Number				10f. Zip							•			
	s 23g	Funeral	1303 Marquis Ct.	10 Was Daged	ant Francis II C	12.1		047	i- Orin	in2 (Can	nity Van as Na						
	er de	nu	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Deced Armed Forc 1 Tes 2	es?/	13.	f Yes, spec	offy Cubar	n, Mexican,	Puerto I	city Yes or No- Rican, etc.)	E	Black, White,				
36	rs aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes	2 No	Specify:			Spe	cify: Whi	te			
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f ehow ite Mudical Exer'il et mast be notified at		15. Decedent's B	ducation		16a. Deced	dent's Usua	I Occupa	ition			16b. Kind of	Business/Ir	ndustry			
15	n n	Completed	(Specify only highest gi	rade completed)	(a. 5.)	(Give	kind of wor DO NOT us	rk done d se retired,	luring most)	of workir	ng	Hospi	tal				
12	filed within Hygiene. other than	Elo	Elementary/Secondary (0-12)	College (1-4	3	Nurs	е										
	Hyg othe	Be C	17. Father's Name (First, Middle, Las	t)					18. Mother	's Name	(First, Middle,	Maiden Sum	ame)				
an	Mental Merital or arked o	To B	Leonard Rehbein						Mari	on i	Mules						
Maryland	S D E E	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Number	r or Rura	l Route Numbe	r, City or Tov	vn, State, Zij	p Code)			
Ž	nd 2 allth a 27 is		Thomas V. Butz $/$	husband	d	1303	Marc	uis	Ct. F	alls	ston, M	D 2104	7				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	l	20a. Method of Disposition		COO	ce of Dispo	sition (Nan	ne of ther place	e)		Jun 20	20c. Locatio	n - City or T	own, Slate			
9	ent o ent o tr: If		1 ☐ Burial 2 ☐ Cremation 3 i 1 ☐ Donation 5 ☐ Other (Spec		ate		,		1			Belts	ville,	Maryland			
₫	artm ortar injur		21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Cremation and Funeral Alternative:														
Ba	Depared Impo		> X Llab	06	NOONS									arvland 21286			
	A.		23a. Part1. Enter the disease, or cor	mplications that cau	used the death.								1	Approximate			
			shock, or heart failure. List only Immediate Cause (Final		_		1	0 -	. /	1				Onset and Death			
	Physician /Medical		disease or condition resulting in dealh)	a	east Ci	, - ,	4171	1 1	refas	rasc	ک:			10 years			
100	Examiner			D00 10 (0)	ras a conseque	ince oi).								·			
		er	Sequentially list conditions,	b. Justo (or	r as a conseque	nca of j.											
	nsit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
	ate be executed hysician and the burial-transit	Xal	that initiated events resulting in death) Last	C Due to (or	r as a conseque	nce of):											
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687	ficate p phy.	edic		· · · · · · · · · · · · · · · · · · ·													
XO	leath certific attending p	Physician/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outco								23d.	Date of deliv	rery			
ã	atter I for u	clar	in the past 12 months?		th 2 ☐ Fetal d nt at lime of dea		JEctopic pr Other (sp						Month	Day Year			
Ö	that the de ed by the detached	ıysi	9 Unknown	9□ Unknow	vn												
صّ	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	y P	Part II. Other significant conditions	contributing to dea	th but not result	ing in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco use c	ontribute to t	the cause of death?			
sp.	uires sign	d by									1 🗆 Y	es 2 No	3 Pro	bably 4 Unknown			
Records,	w requir been si should	Completed									24a. Was	an 24	b. Were auto	opsy findings available			
Re	The law ate has b page 2 si	E G									autop perfor	rmed?	prior to co death?	ompletion of cause of			
8			25. Was case referred to medical						OC Disease	of Dooth	1 Yes	2.00 No	1 L Yes	2 L No			
of Vital		o Be	examiner?	Hospital:	patient 2□E	R/Outpatier	nt 3 DC	Othe	20		(<i>Check only o</i> ne 5 X Resid		Othor (Cana	(4.)			
o	Phys rthis rat di	\vdash	1 Yes 2 No 27. Magner of Death	-		8b. Time o		8c. Injury Work			28d. Describe h			'ly)			
on	ding h. Afte fune	tion	1 Natural 5 Pending 2 Accident Investigate	28a. Date of (Month)	, Day Year)	Injury	м		(? Yes 2∐N	10							
S	Attending in death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place o	of Injury - At hom	ne, farm, str	eet, factory	, office		2			mber or Rur	al Route Number,			
Division	= 2 # 2	Certification;	4 ☐ Homicide determine	building	g, etc. (Specify)		,				City or Tou	m, State)					
_	Hospital 24 hours a Funeral intely filled			Physicien: To the b													
	24 h 24 h 8 Fur etely	Medical		aminer: On the bas and manne	is of examination												
	onthin To the	Me	29b. Signature and title of certifier	1.	1		290	. License	number			29d. Date sig	ned (Month,	Day, Year)			
	1		1 (olde C/1	atakes	1 M	2		12	435	6		JUNE	20	2005			
1			30. Name and address of person who	o completed cause	of death (Item 2	23a) (Tvpe	Print) L	Veen	ben C	ncest	Certa E	f Fruk	len S	n Balt 2112			
1	0				no	()	2146	= N	unter	ome	Stresion 5	Baltin	14 86 G	21237)-4			
	Sta	ato.	31. Date filed (Month, Day, Year)		gistrar's Signaju			<u> </u>						7 1-100			
	Regist		IIIN 9 1 3	nns l	ace . St	SPO	346										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 21 per fh/dvr 8844 6-23-05 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month GEORGE ELLWOOD CALTRIDER, JR.

Gardlifty Nama (If not institution, dive street and number)

4b. City, Town, or Location of Death 19 2005 11:30 AM June 4c. County of Death 4a. Facility Name (If not institution, give street and number Arnold 788 North Lakeview Drive Anne Arundel | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 11, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1**∑**M 2□F Months 215-05-6857 87 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Arnold Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 788 North Lakeview Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Foreman 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Ellwood Caltrider Sr. Louisa Lula Dudrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Mayo Caltrider, Wife 788 North Lakeview Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 6-2A-A5 ²² Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Mary 21. Signature of Funeral Service Licensee Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ungestive disease or condition resulting in death) Due to (or as a cons of ence of): Sequentially list conditions, if any, leading to immediate cause. Enter U. Jerrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 RUnknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Examine

Physician

/Medical

10a. State

Examiner

Funeral

Director

28e-f show

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238

items

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pernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "ne any njury or other treumatic event, I'm Madia 2006.

Director

Funeral

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Completed

or other treumatic event, the Medical Examiner must be notified at

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

the burial-transit should

attending physician and for use as the burial-trar signed by the at be detached for signed by peeu cate has page 2 s filled in by the funeral After death, Director within 24 hours a To the Funeral i

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

To the Hospitel

Physician/Medical 1 ☐ Yes 2 ☐ No 9 Unknown þ Completed Be Certification: To

29a. Certifier

(Check only one)

Medical

State

Registrar

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 - Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

WD

28b. Time of

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

16964

29d. Date signed (Month, Oay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1509 naconas

31. Date filed (Month, Dav. Year) JUN 2 1 2005 32. Registrar's Signature

		ļ	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of l		lental Hy	giene Reg. No. 200	5 20478
	Physici /Medio		Decedent's Name (First, Middle, L DAVID	ast) ARK	ζ.			2. Date of De Month		3. Time of Death 21 20 PM
	Examir		4a. Facility Name (If not institution, gi	Bayview N	ledical (entr	Ba	or Location of Death		4c. County of D	eath
	Funeral Director		5. Social Security Number 6. 213-28-2634 Usual Residence of Decedent	Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthday .75 Yrs.	Months Days		8. Date of Bir (Month, Di	y, Year)	Birthplace (State or Foreign Country) Bryland
	Maryland a-f show	tor	10a. State 10b. County Maryland N/A		10c. City, Town or L Baltimo					10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 5166 Wright Avenue			10f. Zip Code 21205			10g. Citizen of What	Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked othar than "natural; or itams 23a or 28a-f show or othar traumatic evant, the Medical Examinant be notified at	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 1 1 Yes, Give Year or Dates	? No	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ XNo	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	o- 14. Raca - A Black, W Specify: W	
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Giv	DO NOT use retire	during most of work	ing	16b. Kind of Busine Duralite	ss/Industry
Maryland ?	2 should be filed within and Mental Hygiene. is marked othar than sumatic evant, the Ms	To Be C	17. Father's Name (First, Middle, Las Clarence James Clark					e (First, Middle nces Donn	, Maiden Sumame) Pell	
	and 2 should leath and Men m 27 is marke		19a. Informant's Name/Relationship Patricia Bart/Niece	(Type, Print)		ing Address (Street phin Court	and Number or Run Timonium M		er, City or Town, Stati 21093	e, Zip Code)
Baitimore,	Pa nen nen ury		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 → 4 □ Donation 5 □ Other (Spec	ify)		osition (Name of matory or other pla Faith	_{сө)} 6/20,	/05	20c. Location - City Baltimore Ma	
Bait	Departr Departr Imports any Inji		21. Signature of Funeral Service Lice	Wetto	5		Road Balt		yland 21214	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Non Due to (or a	Small Luis s a consequence of):			or respiratory a	rrest,	Approximate Interval Between Onset and Death Months'
,8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examine	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	s a consequence of):					
.O. Box 6	it the death certific by the attending pl tached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
rds, P.	quires that an signed b uld be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 Unknown
Il Record		Completed							osy prior death	autopsy findings available o completion of cause of ? es 2 □ Ño
f Vital	Physician: Th this certificate al director, paç	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	ient 2 ER/Outpatie	nt 3□ DOA Oth	26. Place of Death		one) dence 6 □Other(S	pecify)
Division of	or Attending ifter death. Diractor: After in by the funer	Certification:	27. Manner of Death 1	28e. Place of Ir	ay Year) 28b. Time of Injury njury - At home, farm, si	M 1	Yes 2 □No		how injury occurred Street and Number or wn, State)	Rural Route Number,
_	To the Hospital within 24 hours a To the Funaral I completely filled	Medical Co	29a. Certifier Check only one) Check only	hysician: To the bes miner: On the basis and manners	t of my knowledge, dea of examination and/or in tated.	th occurred at the ti nvestigation, in my o	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and manner date and place, and c	as stated. ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier Accum	golin a	MIZ	29c. Licens			29d. Date signed (Mo	onth, Day, Year) 5, 2005
F	1		30. Name and address of person who Far am Decinic MD	Johns Hopk	dea (Item 23a), (Type	Moderal G	onto 494	o Easter	n Avenue f	5, 2005 Saltimore, Mary
	Sta Registr	100	31. Date filed (Month, Day, Year) JUN 2 1	2005 32 egis	trar's Signatur	arde)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Them/19a, per Inf (845) 7/05 TI State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Yeer 11 05 8:25A 06 /Medical Catherine T. Carroll 4a. Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince Georges Prince Georges HOspital Cheverly If Under 1 Year If Under 24 Hrs.

Vonths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 06 09 Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 KF Yrs. Director 75 Wash. D.C. 579-34-1235 Usual Residence of Decedent Show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Exercises must be notified at Director Yes 2 No 28a-f Prince Georges MD Suitland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3936 Suitland Rd. #102 20746 Items 23a USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc hours after 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 72 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Congressional Liason Officer U.S. Government 4 yrs. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Roscoe Thomas Catherine Wormley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur U. Carroll/HUsband 3936 Suitland Rd. #102 Suitland, MD. 20746 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6-20-05 Triangle, VA. Quantico National * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home once (x marshall 1 4217 9th. St. N.W. washington, D.C. 23a. Part 1 Ent in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician henal Acute failure /Medical resulting in death) Due to (or as a consequence of Examiner Hebatorenal syndrome Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of); Examiner certificate be executed as the burial-transit ur cancer Due to (or as a consequence of): physician Physician/Medical esn. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown The law requires that the 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate 1 ☐ Yes 2 No Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1X Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 158322 M.D 06 11 1 ARL 2005 30. Na and address of person who completed cause of death (Item 23a) (Type, Print) 1 SHIKHA KHOSLA, MD 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785 31. Date filed (Month, Day, Year) 2 1 2005 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JUNE 16 Ch 5. S& AM THOMAS COLE, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number Examiner Lutherville timore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours I Min. Month, Day, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 6-24-8 Yrs. Director Baltimore, MI Usuel Residence of Decedent filed within 72 hours after daath with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Wes Decedent Ever in U.S.
Amped Forces?
1 BY Yes 2 No FORGAL
If Yes, Give
Year or Dates: Conflict Race - American Indian, Black, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 ☐ Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 No Specity: Whit Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use relied)

| StoadCaste(15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kadio Television Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: if Itam 27 is marked other than 2 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cole (wite) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cole 722 Baltimore, 20b. Piece of Disposition (Neme of cemetery, cremetory or other p 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) important: if it any injury or Evans funera Name and Address 21. Signature of Funeral Service Licenses 2325 405K 23a. P. 11 Ent r the cit ase, or complishions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart finder. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final diseese or condition resulting in death) /Medical . TRANSITIONAL CELL CARCINOMA morum Examiner Due to (or es a consequence of): LEFT URETER Examiner ARTERY DISEASE or Attanding Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last HYPERTENSION Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of mente 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? 21/No 1 Tyas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 27. Menner of Death 5 Pending investigation 1. Neturel eftar daath. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier upte MD D0053150 COUPTH 9 65 STATION GO ROWD SUITE 110 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) ShAWNMALA 31. Dete filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 933AM Month /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death BelAIR If Under 1 Year If Under 24 Hrs.

Ours Hours Min. ty Number Funeral Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 10 € Director Yrs. 0 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location , or items 23e or 28a-f show 10d. Inside City Limits Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Eve Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ f Yes, Give Year or Dates: 2 No 3
Widowed 4 Divorced Specify: "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Important: If item 27 is marked other then any injury or other treumatic event, Ine Meonce. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental Selmo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BELAIR MD 2101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Teremation 3 Removal from State 4 ☐ Donation) 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Evans chapel of memories ForestHill 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Friysician METABOLI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) TEPATIS YEARS to (or as a consequence of) Box 68760. YEARS by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for i 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes Certification: To 1 [] Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

(Type, Print)

HESAPEAKE MEDICAL CENTER BELAIR

lame and address of person who complete I cause of death Umm

2005

31. Date filed (Month, Day, Year)

MU

32. Registrar's Signature

			1- State of Maryland / Department of Health and Certificate of Death		2000	0482
7	Physic	an	Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	. Time of Death
	/Medi Examii	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	June 1	4c. County of Defath	045 pm
ja d	- Adiiii		Maryand General Hospital Baltimore C	Hy	NA	•
	. Funeral Director		5. Social Sècurity Number 6. Sex 12 F 7. Age (In yrs. last birthday) 15 Under 1 Year If Under 24 Hrs. Months Days Hours Min.		(ear) 9. Birthplace Country)	(State or Foreign
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. I	Inside City Limits
	the Ma 28a-fa	ector	10e. Street and Number			Yes 2 □ No
	ath with the Marylan 23s or 28s-1 show	ai Dir	106. Street and Number 106. Zip Code NIA	10g	J. Citizen of What Country?	
920	rs after de I', or items	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Ir Black, White, etc.	ndian,
215-0036	e * 3	ieted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	king 16	b. Kind of Business/Industr	у
212	ifiled within Hygiene. othar than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Inc. DO NOT use retired)		NA	
Maryland	2 0 2 0 0	To Be (17. Father's Name (First, Middle, Last)	ne (First, Middle, Ma	iden Sumame)	
Mary	2 g is		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rid	ral Route Number, C	City or Town, State, Zir Cod	a) 2176
	ges 1 and t of Health If itam 27 or other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City or Town,	10.
Baltimore,	Pa men ury		1 Burial 2 Incremation 3 Removal from State 1 Donation 5 Other (Specify) 1 DAVIEW CREM.	\$005 I	BALTO.	UD.
Bal	permit. Departr Importa		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility KHLDA F-H	2829 H	LUDSONS	7.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		Inte	roximate rval Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ASPRATION PROMING Due to (or as a consequence of):	C	Ons	et and Death
	Examiner	10	Sequentially list conditions, b. LIVER CIRRho3/3			
/ _	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
68760,	ficate be executed physician and sthe burial-transit	ш	resulting in death) Last Due to (or as a consequence of):			
		Medicai	d.			
.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day	Year
ds, P.	ires that signed b d be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cau	
of Vital Records,	aw requir as been si 2 should	Completed	,	1 ☐ Yes 24a. Was an		4 Unknown
al Re	iician: The lav certificate has rector, page 2			autopsy performed 1 Yes 2	24b. Were autopsy find prior to complete death? No 1 Yes 2 1	
Vita	Physician: this certificaral director, I	To Be	OXAMINION:	h (Check only one)		
	ding Phys After this a funeral dii		1 Natural 5 Pending (Month, Day Year) Injury 28b. Time of 28c. Injury at Work?	28d. Describe how in	6 Other (Specify)	
Division	l or Attanding after death. Diractor: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street	t and Number or Rural Rou	te Number
۵	oital or urs afte aral Dir		building, etc. (Specity)	City or Town, Si	tate)	o vombol,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the c	ause(s)
)	To To Con	2	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day,)	'ear)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11	4/14/05 L	
100	Sta	e ,	31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	HOSpeia		
	Registra		JUN 2 1 2005 Serve & Sparke			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 15, 2005 Arnold G. Callan JUNE 5:14 P M /Medical 4a. Facility Name (If not institution, give street and number)
107 SOUTH POTOMAC STREET 4b. City, Town, or Location of Death BALTIMORE CITY Examiner 4c. County of Death 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Or Country) Sept. 12,1938 Pennsylvania Funeral Birthplace (State or Foreign Country) Months Days Hours Min. 1**⊠**M 2□F Director 219-26-5144 Yrs. 66 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1X Yes 2 No Maryland Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 107 South Potomac Street 21224 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Technician Radio & T.V. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George H. Callan Rose Mary Rice 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Callan (Brother) 2115 CCedar Circle Drive Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Balto/Wash Crematory 6/20/2005 ^¹ 4 □ Donation 5 □ Other (Specify) Laurel, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service I. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Atheroscleratic Cardiovascular disease or condition resulting in death) disease complicated by porthermia /Medical Due to (or as a consequence of): Examiner Sequential V list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Phyelclen: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Aunknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 1 Yes 2 1 No 24a. Was an autopsy performed? 1 Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 XOther (Specify) AT SCENE Certification: To 1y∑ Yes 2 □ No in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred . After Injury 1 Natural 5 Pending subject exposed to hot environment 6-15-05 Found 5:10 M death. 1 ☐ Yes 2 🕱 No 2 Accident
3 Suicide investigation tound Director: 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 107 South Portoined Street. Baltimore 4 Thomicide filled within 24 hours a To the Funerel I At home Street. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number OCME 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 JUNE 16, 2005 hi, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 LING 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

2005

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State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 1 2005

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32. Registrar's Signature

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Funeral Director		5. Social Security Number 461-22-7944 Usual Residence of Decedent	7. A	ge (In yrs. last birth			Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da JAN. 12	h y, Year) 192	9. Birt Co	hplace (State or Foreignintry) TEXAS
Mon to		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limit
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23a o	a D	1840 REISTERSTO	WN ROAD				21208		20		USA
ems er mi	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Decede	ent of Hispar	nic Origin? (Spi	ecify Yes or No-		14. Race - Ame Black, White	rican Indian,
ual Hygiene. od other then "natural", or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Marned 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 If Yes, Give Year or Dates:	No	1 🗆 Yes 2		овсіту:	Thous, sto.,		Specify:	WHITE
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nd Mental Hygiene. marked other then imatic event, the M	a)	17. Father's Name (First, Middle, Last)			NELSI ENS		Mother's Name	(First, Middle,			
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m 27 I		GARY COHEN / SO	N		350 POPP		- ARVA	DA, CO	8000)7	
0		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Removal from State	20b. Place of Cometery,	Disposition (Name crematory or oth	e of her piace)		ate	20c. Lo	cation - City or	Town, State
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after death, Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At home, farm c. (Specify)	, street, factory,			8f. Location (Si City or Town	treet and n, State)	Number or Rui	ral Route Number,
within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 29 Medical Examone)	sician: To the best ner: On the basis of and manner st	i examination and/	death occurred at or investigation, in	the time, da	ate and place, a	and due to the co	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
within Fo the	Me	29b. Signature and title of certifier			29c.	License num	nber	2	9d. Date	signed (Month	, Day, Year)
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	1	30. Name and address of person who c	ome atted cause of a	leath (Item 23a) /Tu	(no Print)					-	

DHMH 17 Rev 1/2001

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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Birth	Vaar			lace (State of	or Foreign
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	D N		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside C	ity Limits
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	r 28a-	Funeral Director	Maryland Carr 10e. Street and Number	oll County	7		10f. Zip		sburg	1		l0g. Citi	zen of Wha	t Coun	try?	
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	1 and Heall tam 2		20a. Method of Disposition	(2003)	20h Plac	a of Disno	cition /Nag	na of	1		Date	20c. Lo	cation - City	or To	wn, State	
JOE	Pages nent of i int: If it		PI⊅Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S				of Fa			6/18	3/2005	Ros	sville	e, I	Maryla	ınd
Baltimore,	permit. Pages 1 and 2. Department of Health a important: If itam 27 is any injury or other trauonce.		21. Signature of Funeral Service	yal F	Home of	Dun	dalk,	Inc	222							
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Ö	al or /	Certification:	4 Homicide	buildi	ng, etc." (Specify)						City or Town	n, State)				
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1	0/1		30. Name and address of person	KINA			Print) 37	5	Hosp	Site	ed Br	no	Ini 210	te 61	208	
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		•	For State Registrar		State	of Maryla		artment rtificate					giene Reg. No	000	2	0487
	Physici		Decedent's Name	(First, Middle,	V - 1	exter	-			-		2. Date of De Month	h Day Year		3. Time of Death 5:487 M	
	/Medio Examir		4a. Facility Name (If	-	give street and	number)		4b. City, 1		Location of		4c.		C. County of Death		
	Funeral Director		5. Social Security Nu 216–24–74	39	5. Sex 1 ☐ M 2 🖼 F		s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 11-03-	v. Year)		Country	ce (State or Foreign y) land
	and w		Usual Residence of 10a. State	10b. County		10c. (City, Town or Lo	cation							100	d. Inside City Limits
	Marylan f show	ō	Md	Carro1	1	S	ykesvil	16								1 Yes 2 No
	r 28a	rec	10e. Street and Num				ykesvii	10f. Zip	Code				10g. Cit	izen of What	Countr	y?
	h with	al D	7200 Thi	rd Aven	ue-C141			2178	84				U.S	.A.		
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28s-f show or other treumatic event, the Medical Examble must be rediffed at	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed		Armed 1 ☐ Ye If Yes,	ecedent Ever in Forces? s \$2 No Give r Dates:		Was Deced If Yes, spec	rfy Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	1-	14. Race - A Black, W Specify:		c.
21215-0036	12 should be filed within 72 h h and Mental Hygiene. 7 is marked other then "natu treumatic event, the Medical	Completed	(Special Speci	, , ,	grade complete College	d) a (1-4or 5+)	(Give	dent's Usua kind of won DO NOT us acher	k done o	lurina mos.	t of workir	ng		ind of Busine		stry
	Hygie Hygie other ent,		17. Father's Name (i	First, Middle, La		-	10	actici		18. Mothe	r's Name	(First, Middle,		ucatio	n	
Maryland	ould be Mental narked o	To Be	Harry Ber	njamin	Frey					F1	oren	ce Mari	ion l	Wright		
ary	shou ind M mar umat	-	19a. Informant's Na	me/Relationshi	p (Type, Print)		19b. Mailin	ng Address	(Street a			l Route Numbe				Code)
	1 and 2 Health a tem 27 is		Edward B		r	20b	7200 Place of Dispo	Third	Av	enue	-C14	1 Syke	20c. Lo	Lle, M	ary or Tow	Land 21784 n, State
JO L	ages ent of nt: If i		1 D Burial 2 D	☐Cremation 3	3 □Removal fro		сөптөтөгү, стөг	natory or ot	ner place	9)						
Baltimore,	permit. Pages 1 and Department of Health importent: if item 27 any injury or other tr once.		21. Signature of Flur			- We							rs Fu	ineral	Di	ryland rectors In and 21133
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the shock, or heard Immediate Cause (f disease or condition resulting in death) Sequentially list conif any, leading to implease. Enter Under Cause, Utsease or in that initiated events.	t failure. List or Final 1 Inditions,	a. Due	It caused the den each line. to (or as a consi	Myo(8						rrest,		li C	Approximate niterval Between Driset and Death Z
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	resulting in death) L	ast	d	to (or as a conse										
P.O. Box	that the death certific led by the attending p detached for use as	Physician/Me	23b. Was decedent in the past 12 r 1 Yes 2 2 9 Unknown	onths?	1 Liv	outcome of preg e birth 2 TFe egnant at time of known	etal death 3	Ectopic pre Other (spe				-		23d. Date of Month		ay Year
	w requires that been signed b should be deta	by	Part II. Other signific	cant condition	s contributing to	death but not re	esulting in the u	nderlying ca	use give	n in Part I.		23e. Did t				cause of death?
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referre		Hospital:		/		Othe			(Check only o				
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Division	al or Attending after death. I Director: After d in by the funer	Certification:	3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Pla	ice of Injury - At ilding, etc. (Spec	home, farm, str cify)	eet, factory,	, office		2	8f. Location (S City or Tox			Rural F	Route Number,
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	10		30. Name and addre		no completed ca	ause of death (It	em 23a) (Type,	Print)	e 3	97	~s	tsume	ex	MD,	2(1	57
	Sta Registr	_	31. Date filed (Month		2005	295 St Registrar's Sig	nature Age	Me)				

		1 - For State Registrar	State	of Marylai	•	artmen <i>rtificate</i>					giene Reg. No.	105	20488
		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath Day	Year	3. Time of Death
Physici /Medic		Robert W. Davis	s, Sr.							June 1	9 , Ž00!		7:45 A M
Examin		4a. Facility Name (If not institution	-	umber)				Location of	of Death		4c. Cour	nty of Death	
		2237 Wilkens Av		T =			ltin		0411			n/a	
Funeral Director		5. Social Security Number 219–50–2037	6. Sex 1 M 2 ☐ F	7. Age (In yrs 52	. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bird Jun 20	, 1952	Cou	place (State or Foreign ntry) rland
and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
danyli f sho	ŏ	Maryland n/a		i	Baltimo								1 X Yes 2 □ No
the 288	Director	10e. Street and Number				10f. Zip	Code	-			10g. Citizen o	of What Cou	ntry?
3a or	<u></u>	2237 Wilkens Av	enue				2122	8			Ţ	JSA	
deatl	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U	J.S. 13.	Was Deced	dent of His	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)	- 14. R	ace - Ameri lack, White.	
Iryiand Z IZ I 3-0030 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-1 show maric event, it a Maclical Examilier i watter colling at	by Fu	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Tes	2 No Sive	1	1 □ Yes 2		Specify:		riican, etc./	Spec	,	White
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yian	2	John E. Davis	hi- (T Dri-A)		405 14-10	-14 44-0-1	(2)			. Fowler			- 0. 1.1
Mal d2st d2st thanc traun traun		19a. Informant's Name/Relations Diana L. Davis				-				al Route Numbe			
Heal Heal		20a. Method of Disposition	\ MITE	20b.	Place of Dispo					Date	20c. Location		
ages int of t: If it		1 ☑ Burial 2 ☐ Cremation			cemetery, crer pudon Pa		ther place	9)	6/23	/05			Maryland
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Daltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta important: If them 27 is marked any injury or other traumatic anone.		KK. L.S.	62	Qua:									nd 21229
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea									Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a. M	ETAST	ATTIC	ANC	IRE	ATIC		ARCIN	JOHA		4 HONTHO
/Medical Examiner		resulting in dealin)	Due to	o (or as a conse	quence of):								
	Į.	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conse	quence of):								
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cate be executed physician and the burial-transit	dical		d		<u></u>			<u>.</u>					
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death certiff death certiff e attending d for use as	lan/l	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr birth 2 ☐ Fet	al death 3	Ectopic pr						Date of deliver	ery Dav Year
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hat the sed by detac	/ Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use co	ntribute to t	he cause of death?
usines to signeral si	d by									1 🗆 Y	es 2 No	3 🗌 Prol	oably 4 🗀 Unknown
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The ta	Шо									autop perfor	med? 2 No	death?	mpletion of cause of 2 No
VICAL iclan: 1 certifical ector, p	e e	25. Was case referred to medical						26. Place	of Death	(Check only o			20.10
OI VIIA Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 € No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DO	A Othe	r. 4 □ Nu	rsing Hor	me 32 Resid	lence 6 🗆 C	ther (Specia	(y)
ng Phy Iter this		27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	2	8c. Injury Work	at ?		28d. Describe h	ow injury occ	urred	
Attending or death. ector: After by the fune	catl	2 Accident investig	gation not be			М		'es 2 □ l					
DIVISION at or Attending s after death. It Director: After d in by the fune	Certification:	4 Homicide determ	ined 200. Place	ce of Injury - At I ding, etc. (Spec	nome, farm, str ify)	eet, factory	, office		1	28f. Location (S City or Tow		nber or Rur	al Route Number,
To the Hospital or Attending Physician: The law within 24 burus alter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier Certifyin (Check only one) Certifyin	g Physician: To the Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge, death ation and/or inv	occurred a	at the time in my op	e, date an inion, dea	d place, a	and due to the ded at the time, d	cause(s) and r date and place	manner as s e, and due t	stated. the cause(s)
Го th e vithin Го the	Me	99b. Signature and title of certifie	1	C 1		29c	. License	number			29d. Date sigr	ned (Month.	Day, Year)
- > F 0		Jana A	- 1	this.	HID	1	DO	0191	419		JUNE	E De	,2005
1.		30. Name and address of person	who completed car	se of death (Ite	/ 5	Print)	, 1		D			1 -	^
U		DIANA H.		A5 4	00 0	ATON	1 +	JE,	10	ANTINE	ORC,	MD	31227
Sta Registr		31. Date filed (Month, Day, Year) 0.000	2005	Agistrar's Sign	ature	1 0							

DHMH 17 Rev 1/2001

JERRY EVANS 05-4108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend ietm#2, perMF, G844, 6/28/05 II

		1- State of Maryland / Registrar	Department of Health and M Certificate of Death	lental Hygiene 2005 2048
Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day 2005 3. Time of Death
/Medi	cal	Jerry Jerome Evans, Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JUNE 16, 2004 0459 A M
Exami	ner	JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	N/A
Funeral Director		5. Social Security Number 215-98-3335	rithday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) Sept. 25,1981 Maryland
fand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Too	vn or Location	10d. Inside City Limits
e Many ie-f sh iifled	ctor	Maryland N/A	Baltimore	1 X Yes 2 □ No
th with the 23a or 28	al Director	10e. Street and Number 1106 Wilmot Court	10f. Zip Code 21 20 2	10g. Citizen of What Country? USA
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was 13 a or 28e-1 show other treumatic event, It e Marical Examiner matter and itself and other treumatic event, It e Marical Examiner matter and itself and i	by Funeral	11. Marital Status 1 ★ Never Married 2 ★ Married 3 ★ Widowed 4 ★ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	necify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
ithin 72 ho ie. ien "netur Marical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ng Security System Co
filed w Hygier ther th		10th grade	Telemarketer	(First, Middle, Maiden Sumame)
should be filed within and Mental Hygiene. Is marked other then sumatic event, It e Me	To Be	Jerry Jerome Evans, Sr.		uh Johnson
permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. In frem 27 Is marked other then "sny injury or other treumatic event, It e Marane.	-	19a. Informant's Name/Relationship (Type, Print) Estelle White / Grandmother 4		Baltimore, Maryland 2121
Pages 1 and of Heigher of Heigher International Institution of the Irry or other		IX Dunal 2 U Cremation 3 Unemovalitum State	of Disposition (Name of bry, crematory or other place) 6/23 Memorial Park	20c. Location - City or Town, State Woodlawn, Maryland
permit. Pages Department of Importent: If if eny injury or once.		21. Signature of Edneral Service Licensee	22. Name and Address of Facility Cha 5240 Reisterstow	tman-Harris Funeral Hom n Rd Baltimore,Md 21215
		23a Part1 Enter the disease, or complications that caused the death. Do shop, or hear failure. List only one cause on each line.		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	gunshot wounds	•
Examiner			oi).	
sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events c.	of):	
icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C	of):	
te be e ysiciar ne buri	dical	đ		
ath certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
uires that the de signed by the a Id be detached t	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow
The law requi	ompleted			24a. Was an autopsy performed? 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No
ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	
Phys this ral di	J.	the state of the s		me 5 Residence 6 Other (Specify)
nding I uth. r: After e funer	atlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation -16 - 6 4:	Injury Work? 3 A M 1 □ Yes 2 14 No	subject was shot
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State) IICO BIK of McA/6
To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge and manner stated.	e, death occurred at the time, date and place, and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated.
To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
4		My hi, m.D	OCME	JUNE 16, 2005
1		30. Name and address of person who completed cause of death (Item 23a)		Baltimore, Maryland 21201
Sta Regist		31. Date filed (Month, Day, Year) JUN 2 1 2005 32. Registrar's Signature	Sparte	

			= Stata Registrar	epartment of Health and M Certificate of Death		ene 0 0 5	20490
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Henry William Emory		2. Date of Death Month June 18	, 2005 Year	3. Time of Death 8:00 PMM
	Exami	ner	4a. Facility Name (If not institution, give street and number) 1009 Kelso Drive	4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arur	ndel
	Funeral Director		5. Social Security Number 231-30-1808 6. Sex 1 MM 2 F 71 Age (In yrs. last birthe 71 Yr	Months Days Hours Min	8. Date of Birth (Month, Day, Y) Oct. 17,	ear) Coun	lace (State or Foreign try) ginia
	ne Maryland Sa-f show	ctor	Pennsyl- vania			10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23e or 21	ral Director	20 Milgir Modu 100 3	10f. Zip Code 17325	10g	. Citizen of What Coun USA	try?
9000	72 hours after death with the Maryland netural', or Items 23e or 28a-f show disal Evanifrer must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whit	etc.
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ed other then "netural", or items 23e or 28a-f show of other then "netural", or items 23e or 28a-f show event, the Mudical Evantiner must be prufiled at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) De:	ecedent's Usual Occupation give kind of work done during most of working fe. DO NOT use retired) Livered Chemical	na l	b. Kind of Business/Ind ray Chemica Company	•
yland	should be fill and Mental Hi marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) Clarence Emory	18. Mother's Name Virgi	nia Gaml	ble	
e, Mai	1 and 2 sh Health and Sm 27 is n ther treun			lailing Address (Street and Number or Rura 90 Knight Road Lot 3		ity or Town, State, Zip (urg, PA 17	325
Itimor	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic es <u>once</u> .		20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses	Ridge Cemetery 6/22/	2005 Pa	ikesville,	Maryland
Ba	permi Depa Impo		23a. Part. Ster the disease, or complications are sused the death. Do not shock or hear failure. List only one cause on each line.	Burgee-Henss-Seitz 3631 Falls Road, B	Funeral altimore	Home, Inc. Maryland	21211
	Physician /Medical Examiner		disaction and the same of the	Heart Fai			Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, I sating to Infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):	ACTERY VIX	zase		
O. Box	death cer e attendir id for use	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month D	y Day Year
ecords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I.	23e. Did tobacc	couse contribute to the	cause of death?
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lo uo	ding Phys h. After this funeral di	To B	examiner? 1 Yes 2 Vo Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 2 Accident investigation	of 28c. Injury at 28		6 Other (Specify)	
DIVISION	affe Dir Dir	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Sf. Location (Street City or Town, Sta	and Number or Rural F ate)	Route Number,
	the Hosp hin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	d due to the cause I at the time, date a	(s) and manner as state and place, and due to th	ed. ne cause(s)
	1		29b. Signature and title of certifier Company Victor Delay 30 Normal and additional of certifier victor and additional	29c. License number D 29 391		Date signed (Month, Da	2005
) Stat		30. Name and address of person who completed cause of death (Item 23a) (Type Ben and IV (To R D) Bo. 31. Date filed (Manth Pay, Year) 32. Registrar's Signature		ne Tre	e Road	Mary land
	Registra	r	JUN 2 1 2005 Par				21208

			For Stata Registrar		State of	f Maryla		artment e <i>rtificate</i>			nd Ment	tal Hygie _{Rag}	ne)	005	204	91
	Physici	an	1. Decedent's Name									ate of Death fonth	Day	Year	3. Time of	
	/Medic	al	4a. Facility Name (II	A. Earp J		mber)		4b. City.	Town, or	Location of I		me		inty of Deat		> P "
	Examin	er	C. 0	1.1	autho			Bo	111	mor						
ş*	Funeral Director		5. Social Security N 219-01-6	umber 6. S	M 2□F	7. Age (In yrs 88	s. last birthday Yrs.	/) If Under Months		If Under 24	4 Hrs. 8. D	ate of Birth Nonth, Day, Y 2/23/19	9ar) 917	9. Bird Co Man	nplace (State of untry) yland	r Foreign
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town or I	_ocation							10d. Inside Cit	y Limits
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	or 28a	Director	10e. Street and Nun					10f. Zip				10g		of What Co	untry?	
	ath wi	rai		en Choice		Apt. 8				228	-0.407.	N		S.A.	t	
36	4 within 72 hours after death with the Maryland Jiene. r then "naturel", or Items 23a or 28a-f show Ite M. Jical Ezandier cutt be mulfied at	by Funeral	 Marital Status Never Marria Widowed 	ed 2 Married	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 No	U.S. 13	If Yes, spec		spanic Origir n, Mexican, I Specity:	n / (Specify Y Puerto Ricar	res or No- 1, etc.)		Black, White	ncan Indian, a, etc. iite	
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<u>a</u>	₩	To Be		A. Earp S	r.					Helen	Chall			·		
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Balti	permit. Pages 'Department of H Importent: If ite any injury or of		21. Signature of Fu	neral Service Licen	Tal.	need									f Cator , MD 21	
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	/Medical Examiner		resulting in death)	ſ	Due to	or as a conse	equence of):	/								
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687	ificate g phys	edical			. d								I Section			
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٦.	ss tha	by	Part II. Other signif	icant conditions o	ontributing to de	eath but not re	esulting in the	underlying ca	ause give	en in Part I.	2	23e. Did tobad			the cause of de	
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ion	uttending P death. ctor: After y the funer	atio	1 Accident	5 Pending investigation		th, Day Year)	Injury	М		r Yes 2 □ No	0					
Division of	iel or Attens s after deatl el Director: ed in by the	Certification:	3 Suicide 4 Homicide	6 Could not be determined	206. Flace	of Injury - At ng, etc. (Spec	home, farm, s cify)	treet, factory	r, office		28f. L	ocation (Stree Dity or Town, S	et and Nu State)	imber or Ru	ral Route Numb	007,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	iner: On the ba	best of my kr asis of examir ner stated.	nowledge, dea nation and/or	nvestigation,	in my op	pinion, death	place, and d occurred at	the time, date	and plac	e, and due	to the cause(s)	
•	To t To t	Σ	29b. Signature and	title of certifier	1/21	_		290	Dicense 3	SS4	3	29d	Date sig	ined (Month	, Day, Year)	
	5		30. Namé and addre	14. Se	completed caus	se of death (Ite	em 23a) (Type	Print)	2 to	n Ar	enne	Bu	the	nine	, 200 S Wayl	and
*	Sta Registr		31. Date filed (Moni	th, Day, Year)	completed causes and Garage Ga	egistrar's Sigr	Coarl	را								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend items 20a.b.c per fh 8844 6-24-05 vt. State of Maryland Department of Health and Mental Hygiene 1 1 5 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year LETHA FORD June 14 2005 4:30 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12 S CATHERINE STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2XXF Director 72 Yrs 250-86-1481 June 23 1932 SOUTH CAROLINA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 "neturel", or Items 23e 12 S CATHERINE STREET 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 10th grade FARMER/NURSE HEALTH CARE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental 2 MACK JONES FANNIE FORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cartment of Health a Sir Lister Floyd Jr./Son 12 S. Catherine St., Baltimore, Md., 21223 20a. Method of Disposition 20b. Place of Disposition (Name of Date Bal Linore Town, State Metro Crematory TEXamial 2 Cremation 3 □Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 06-18-05 TANCLOWNE, MARYLAND Departi Import any nj once 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Meterstertic CCIPCINOMO 6 months /Medical Due to (or as a consequence of): Examiner Cancinoma bancreatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f 9 Unknown 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Hypentensian, heamt conyestive 1 Yes 2 No 3 Probably 4 Unknown obstrictive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KNESAIMO D364014 6/14/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University specifing helpital Goi south charles St Baltimore min * DESA IMO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 1 2005

32. Registrar's Signature

			For State	State of Man			Health and Menta		La VVV	20493
			Registrar 1. Decedent's Name (First, Middle, La	ast)	CE	ertificate of		Reg. Note of Death	No.	3. Time of Death
	Physici		10.00,00	11	2/20		Mo		Day Year	5:30 PM
3	/Medic Examir		4a. Facility Name (If not institution, gire		J 1274.	4b. City, Town, o	or Location of Death		4c. County of Death	3.30
	Exami		MARYLAND Mas	anie Horn	7	Lacks.	LLINDA		Balifore	302
П	Funeral			Sex 7. Age (// 1 M 2	n yrs. last birthday	/ If Under 1 Year Months Days		te of Birth onth, Day, Yea	9. Birth	place (State or Foreign
	Director		313 17 18,00	10 M 2M L 87	Yrs.		96)		118 1340	JEARD
	land		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	Mary 1 sh	Ď	MARYLAND DALKIAN	00/63	For Ve	SILVIL				1 ☐ Yes 2 ₺ No
	r 28a	Director	10e. Street and Number	1014	- C C 1- C	10f. Zip Code		10g. (Citizen of What Cou	ntry?
	23a o	a D	300 INTRACTIO	oral DRIV	Z	210	30		U.S.A.	
	ams ams	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of I	Hispanic Origin? (Specify Ye an, Mexican, Puerto Rican,	s or No- etc.)	14. Race - Americ Black, White,	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ⊠ No		1 ☐ Yes 2 ☐ No			Specify:	
21215-0036	d within 72 hours after death with the Maryland jaene. Ir than "netural", or Itams 23a or 28a-f show The Medical Examirat must be notified at	q pa	3 Widowed 4 □ Divorced	Year or Dates:	16a Dece	edent's Usual Occup	nation	16h	Kind of Business/In	dustry.
5	n "ne	Completed	(Specify only highest gr Elementary/Secondary (0-12)		(Giv	e kind of work done DO NOT use retire	during most of working od)	100.		4
212	d within giene.	Eo	137 RS	P 102	Schi	1421 LOO	Ster	BE	ALTIMORE.	KILL
ם	be filed stal Hygi of other avent, I	Be C	17. Father's Name (First, Middle, Last	0			18. Mother's Name (First,	Middle, Maide	en Sumame)	
<u>ya</u>	should be and Menta marked umatic av	2	MILIAM	KAROW			ZLIZABET	H K	HTO	
Maryland	C/ 40 = 42		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Rural Route	Number, City	or Town, State, Zip	(Code) 21234
	s 1 and f Health ltam 27 other tr		20a. Method of Disposition	1, FER JR.	20b. Place of Disp	osition (Name of	CKICAD LA	20c	Location - City or To	00
Baltimore,	Pages nent of int: If It		1 ☐ Burial 2 ☑ Cremation 3 [Removal from State	cemetery, cre	matory or other pla	LTT-		~	Charles O
틀			' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		BLL AIR	2. Name and Addre	ess of Facility	10	TH THE	11-41-9UM
Ba	permit. Departr Importa any inji		1 200 H. 200		5	LY COSS	HU 527 0 6 18	Grave.	VILLE MAI	24/2010
	1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the		nter the mode of dyi				Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	metasta	etic mi	HIGNA!	it FiBrous	Histra	cy toma	Onset and Death
	/Medical		resulting in death)	Due to (or as a co		<i>U</i>			//	
п	Examiner		Sequentially list conditions,	b						
	ed isit	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
	xecut and al-tran	Exam	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
68760,	ficate be executed physician and s the burial-transit	alE	· ·	d						
	± 00 €	edical		2						
Вох	h cert endin use	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□Ectopic pregnanc	W.		23d. Date of delive	•
B	e deat he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at tim 9☐ Unknown		Other (specify)	,		Month	Day Year
P.O.	that the death certii ed by the attending detached for use a	Phy	9 ☐ Unknown Part II. Other significant conditions		at reculting in the	underhing enuse on	on in Part I 23	e Did tobacco	use contribute to the	na cause of death?
ds,	Se Ge	d b	AltersColor Voca		-	4 . 12+	and like	1 ☐ Yes		ably 4 Dunknown
Ö	w requir	Completed	11000000) -/1.1/	740,	a. Was an		psy findings available
Hec	0 - 0	E .						autopsy performed?	prior to cor death?	πpletion of cause of
<u>e</u>	iicien: Th certificate rector, pag	a	25. Was case referred to medical	<u> </u>			26. Place of Death (Check	Yes 2004	lo 1 □ Yes	2 No
>	Physicien: r this certific ral director,	o B	examiner? 1 ☐ Yes 2 █XNo	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DDA Ott			6 □Other (Specifi	()
פֿר	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time (of 28c. Injui	ry at 28d. De	scribe how inj		
<u>0</u>	Attending ir death. ector: After by the fune	atlc	2 ☐ Accident investigation	n			Yes 2 □ No			
	I or Attendatter deatt after deatt Director: I in by the	ertification;	3 Suicide 6 Could not be determined		- At home, farm, st Specify)	reet, factory, office		ation (Street a or Town, Sta	and Number or Rura te)	I Route Number,
	Hospital or 24 hours afte Funaral Dir itely filled in	O	29a. Certifier 1 Certifying PI	punision. To the best of m	u kasuladas das	th annual at the st		4-46		
	To the Hospital or Attending Physicien: within 24 hours after deals, safer deals, for the Funaral Director. After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examone)	miner: On the basis of examiner stated	amination and/or in	nvestigation, in my d	me, date and place, and due opinion, death occurred at the	e time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			29c. Licens	se number	29d. D	ate signed (Month,	Day, Year)
			P.t. Tels	ut, Ms.		Da	1460		6/20105	
1	11		30. Name and address of person who		(Item 23a) (Type	, Print)	, rox		1	
1	7"		ROSENT LIBER	to, NO. 3	108 BO	back	Bulo, n	rel. 2	21224	
	Sta		31. Date filed (Month, Day, Year)	2005 32. Agistrar's	Signature	parte	,		/	
	Registr	ar	AALL WIT	LUUS JURGERE	19					

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		-	For Stele	State of Maryland / Departmer		Mental Hygiene	2005 2010
			Stete Registrar 1. Decedent's Name (First, Middle, Last)		le Ul Dealli	Reg. No.	3. Time of Death
	Physicia /Medic		Catherine	Francis		Month Da	7 2005 8 P M
	Examin		4a. Facility Name (If not institution, give s		, Town, or Location of Death	MD 40	c. County of Death
			5. Social Security Number 6. Sex	7. Age (In yrs, last birthday) If Unde	r 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 20F 79 Yrs. Months	Days Hours Min.	(Month, Day, Year)	2005 N. Caretive
Poel	how		10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits 1. Yes 2 □ No
Ž.	8a-fs	Director	My, NIA	VALIMOI	35	10- 6:	
# His	23a or 2 ast be n	al Dire	10e. Street and Number 24-30 9, ATA	10 L AVE.	21229	log. Ci	tizen of What Country?
d 21215-0036	f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exerciner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? If Yes, spe	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	pecify Yes or No- b Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: What
2-0(nature lical E	eted	15. Decedent's Educ (Specify only highest grade	completed) (Give kind of w	ork done during most of wor	king 16b. K	(ind of Business/Industry
21215-0036	iene. r than " Ita Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DAV WAR	KER.	LAUNDRY
	Mental Hyginarked other	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maider	n Sumame)
2	Health and N lem 27 is ma other traums		19a, Informant's Name/Relationship (Typ.	e, Print) 19b. Mailing Address	S (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
more,	20===		20a. Methodrof Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation	20b. Place of Disposition (Na cemetery, grematory or	other place)	7-05 70c. L	ocation - City or Town, State
Baltimore,	E 40 -3		*4 Donation S Other (Specify) 21. Signature of Ineral Service License	22. Name a	nd Address of Facility	TO FREDATION	They Trong 21229
				ations that caused the death. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Athero scleratic	Censalio Va	ascert d	isease
E	xaminer	_	Sequentially list conditions b	Due to (br as a consequence of):			
petho	nd ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions in the conditions of the condition	Convestire Heart	Tailare		
760,	ysician and ne burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequence of):	ry failar	e	
687	2 2	_					
Records, P.O. Box 68	the attending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic; 4 ☐ Pregnant at time of death 5 ☐ Other (s			23d. Date of delivery Month Day Year
s, P.O.	igned by the s	by Ph		ributing to death but not resulting in the underlying	cause given in Part I.		use contribute to the cause of death?
ord	been si should	ted	Porce	nonla		1 ☐ Yes 2	
Il Records,	his certificate has b	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
of Vital	certificate rector, pag	Be c	25. Was case referred to medical examiner?	ospital:	Other	th (Check only one)	a Flother (0-1-1/4)
o a	ar this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 28b. Time of	28c. Injury at	ome 5 Residence 28d. Describe how inju	
vision	death. stor: After / the funer.	atlo	1 Anatural 5 Pending investigation	(Month, Day Year) Injury M	Work? 1 ☐ Yes 2 ☐ No		
Division	s after de	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of tnjury - At home, farm, street, facto building, etc. (Specify)	ry, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
- inac			29a. Certifier 1/2 Certifying Phys	ician: To the best of my knowledge, death occurre	d at the time, date and place		
3	24 hour Funera etely fille	dical		er: On the basis of examination and/or investigatio and manner stated.	n, in my opinion, death occu	ireu at the time, date an	d place, and due to the cause(s)
	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medicel Exemir	and manner stated.		1 001 5	data da San Mara
To Hotel	within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medicel Exemir	and manner stated.		1 001 5	data da San Mara
1	within 24 hour To the Funers completely fills	Medical	(Check only 2 Medicel Exemir	and manner stated.		1 001 5	data da San Mara

State of Maryland / Department of Health and Mental Hygiene 0 05 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Ruxton-Pikesville **Pikesville** Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 217-80-1148 86 09-24-1918 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23s or 28s-f show event, the Medical Exeminar must be notified at 1 Yes 2 No Director Md Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 157 Willgate Road 21117 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Specify: White Baltimore, Maryland 21215-0036 1 Yes 29 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
snt: If item 27 Is marked other than N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose Steriale ပ Joseph Fertitta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 157 Wilgate Road Frances Nunn Owings Mills Md 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite any injury or ot QDCe. 1 Burial 2 □ Cremation 3 □ Removal from State Druid Ridge 06/17/2005 Pikesville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Cando Uces 4 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the part of that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? /es 2 No has page this certificate 1 ☐ Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital: Other: 41 an ursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner at eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Alter 1 Ematural 5 Pending To the numbers after death.

To the Funerel Director: Alt 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitel 29a. Certifier 😂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1scella 1 to drew 0 0 31. Date filed (Month, Day, Year) JUN 2 1 2005 2. Registrar's Signature State Registrar

			1 - State of N Registrar	laryland / Depa <i>Ce</i> a	artment of I			giene () ()	5 20497			
	Dhi.a.i		Decedent's Name (First, Middle, Last)		-		2. Date of Dea		3. Time of Death			
	Physici /Medic		Garnet E. Fairchild				June	16 200				
	Examin	er	4a. Facility Name (If not institution, give street and number	r)	7	r Location of Dear	h	4c. County of Death				
		Ш	112 Glendale Avenue 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Glen Bu		9 Date of Birt	Anne Arundel				
	Funeral Director		215-30-1399	71 Yrs.	Months Days	Hours Min.		Year)	9. Birthplace (State or Foreign Country) PA			
	D		Usual Residence of Decedent				3/24/13	J-1	121			
	rylan thow	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits			
	8e-f s	Director	MD Anne Arundel	Glen Burn					1 ☐ Yes 2 ☐ No			
	with th	Dire	10e. Street and Number 112 Glendale Ave.		10f. Zip Code	1061		10g. Citizen of Wh				
	s 236	erai	11. Marital Status 12. Was Deceden	t Ever in II S 13 1	Was Decedent of H		necify Ves or No-	USA	American Indian,			
· _	r Itan	by Funeral	Armed Forces 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🗗	? {No	If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black,	White, etc.			
93	ral', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates	:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	white			
S O	72 h	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of Busi	ness/Industry			
12	within sne.	Completed	Elementary/Secondary (0-12) College (1-4or	r S.A.)	<i>DO NOT use retire</i> ro11 C1e1	,		Chemica	1 Co.			
וא ס	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)	143			me (First, Middle,	Maiden Sumame)				
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Itams 23e or 28e-f show umatic evant, I'ra Madical Examinar musi is notilined at	To Be	George Walter Stewart			Marth	a Elizab	eth Sutt	on			
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street	and Number or Ri	ırai Route Numbe	r, City or Town, St	ate, Zip Code)			
Σ	and 2 salth s n 27 ls		Mr. Kennard F. Fairchild/s		Glendale	Ave., G1	en Burni	e MD 210	61			
ore	of He of He		20a. Method of Disposition 1		natory`or other pla		Date 0.4000	20c. Location - Ci				
Ĕ	Pag ment tant: I		`4 □ Donation 5 □ Other (Specify)	Meadowri	dge Memor	ial 6/1	8/2005	Elkridge	, MD			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturat", or Itams 23e or 28e-f show any injury or other traumatic evant, Ira Madical Examinar must be notified at once.		21. S. nature) if Funeral Service Licensee	Home 061								
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dyin	ng, such as cardia	or respiratory arr	est,	Approximate Interval Between			
8	Pnysician		Immediate Cause (Final disease or condition	nmediate Cause (Final sease or condition OVAQIA) CBCONDA								
	/Medical Examiner		resulting in death) Due to (or a	s a consequence of):								
		Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or a	s a consequence of):				3				
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
Ć.	exection and rial-tra	Exa	resulting in death) Last Due to (or a									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d									
9	ntifica ing ph as th	Φ	IF FEMALE:					-				
Вох	that the death certifice ed by the attending ph detached for use as t	by Physician/M	23b. Was decedent pregnant 1 Live birth	2 Fetal death 3	Ectopic pregnancy	,		23d. Date of Month	· .			
o.	the a	ysic	1 Yes 2 No 4 Pregnant 3 9 Unknown 9 Unknown	at time of death 5	Other (specify) _							
_	res that this igned by be detact	/ Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?			
Records,	uires n sign lid be						1 🗆 Y	es 2 🖰 No 3	☐ Probably 4 ☐Unknown			
000	ıw require s been siç should b	olete					24a. Was a		re autopsy findings/available			
	The lav te has age 2	Completed					autops perfor	ned? dea	or to completion of cause of ith? I Yes 2 2 No			
Vital		0	25. Was case referred to medical			26. Place of Dea	th (Check only or					
	Physician: this certific ral director,	To B	examiner? 1 Yes 2 Ao Hospital: 1 Inpat			er: 4 🗌 Nursing H	lome 5 eside	ence 6 Other	(Specify)			
0	ding Ph n. After th funeral		27. Manner Death 1 Natural 5 Pending 28a. Date of Inj (Month, D	ury 28b. Time of Injury	Wor	k?	28d. Describe ho	w injury occurred				
<u>s</u>	Attandi death. ctor: A y the tu	cati	2 Accident investigation 3 Suicide 6 Could not be	niums. At home form ats		Yes 2 ☐ No	28f Location (S	reat and Number	or Rural Route Number.			
Division of	or Atlanta	Certification:	determined 200.1 laco of it	njury - At home, farm, str atc. (Specify)	eet, ractory, office		City or Town		or Harai Houle Walliber,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the tune.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bess and manner sand manners	of examination and/or in								
	o tha o tha omple	Mec	29b. Signature and Hitle of pertifier		29c. Licens	number	2	9d. Date signed (#	Month, Day, Year)			
	r s r o		Man D	1/2		13155	7	Tone.	16,2005			
	6		30 Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	11001	0 1	110	// 1 / 1			
	Sta	te		trar's Signature	05 H	perge	Dive	Cylen Bla	me, 14-) 106/			
Ŀ	Registr		JUN 2 1 2005 Seeder	to from	4							

State of Maryland / Department of Health and Mental Hygiene) 20498 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:05_A June 2005 Frieda Garman /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 411 Virginia Avenue Essex Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Hours Days 1 □ M 2 🗙 F 218 36 3152 Director Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show itam 27 is markad other than "natural", or Itams 23a or 28a-f shov othar traumatic avant, the Medical Export ar prust to notified at Essex 1 ☐ Yes 2 No Bultimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 21221 VITAINIA United States Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: by Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Is markad other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Esmerelda Neville Thomas G. Kronawetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun 411 Virginia Avenue Essex, Maryland 21221 Mr. Ray M. Garman (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State / Other (Specify) * 4 Donation Gardens of Faith Cem! 6/16/2005 Rossville, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7922 Wise Ave. Approximate Interval Between Onset and Death Immediate Cause (Final uddin Physician (1150140 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Dronar Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ honuation 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes tha Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0061907 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elso, MD 21221 MD 1/24 Mace Avenue 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20499 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Shelby Marcellus Glenmore

4b. City, Town, or Location of Death

Silver Spring

10:30 P^M

13

06

05

4c. County of Death

Montgomery

Physician /Medical Examiner

Funeral Director For State Registrar

4a. Facility Name (If not institution, give street and number)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23s or 28e-f ehow any injury or other treumatic event, If a Medical Evantiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Layhill Nursing Home		Silver Spring		Montgomer	ту						
	5. Social Security Number 6. Sex 124 M 2 F Valual Residence of Decedent	ge (In yrs. last birthday, 41 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Min		ar) Co	thplace (State or Foreign buntry)						
	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits						
ō	MD	Takoma	Park			1 ⊈ Yes 2 □ No						
rect	10e. Street and Number		10f. Zip Code	100.	Citizen of What Co	ountry?						
0						,						
era	3706 Eastern Avenue	t Ever in U.S. 13.	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian,							
Fu	Armed Forces 1 Never Married 2 Married 1 Yes 2 Married 1 Yes 3 Married 1 Married 1 Married 1 Nove 1	? No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, Whit	e, etc.						
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates		1 ☐ Yes 2X No Specify:		Specify: Bla	ick						
Completed by Funeral Director	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16b.	. Kind of Business	Industry						
ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o)	5+)	kind of work done during most of w DO NOT use retired)	orking								
Con	11th	Cos	smetologist		Hair Sal	on						
Be (17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	en Sumame)							
2	Ralph Glenmore	,	Shir	lean Hall								
	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, 2	Zip Code)						
	Ralph Glenmore/Father	1316	Barnaby Terrace									
	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from Stat	20b. Place of Dispo cemetery, cre	matory or other place)		Location - City or							
	`4 □Donation 5 □ Other (Specify)	Glenwood		8-05 Was	shington,	D.C.						
	21. Signature of Funeral Service Licensee	2:	2. Name and Address of Facility	arshall's F	uneral H	ome						
	Je narshall		217 9th. St. N.W		20011							
	23a. Part I Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not en line.	ter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death						
	Immediate Cause (Final disease or condition Acquired Human Immune Deficiency Syndrome											
	Due to (or as a consequence of):											
	Sequentially list conditions, if any, leading to immediate b. Kaposis Sarcoma Due to (or as a consequence of):											
ine	if any, leading to immediate Due to (or a cause. Enter Underlying Cause (Disease or injury	s a consequence of):										
хаш	that initiated events c.	s a consequence of):										
ai E	350 10 (6) 0											
dic	d											
/We	IF FEMALE: 23c. If yes, outcom	e of pregnancy			23d. Date of deli	iven						
by Physician/Medical Examiner	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year						
ysi	1 Yes 2 No 9 Unknown 9 Unknown											
y P	Part II. Dther significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?						
Q				1 ☐ Yes	2 3 Pr	obably 4 Unknown						
Complete				24a. Was an	24b. Were au	topsy findings available						
mc				autopsy performed	prior to death?	completion of cause of						
e C	25. Was case referred to medicat		26 Place of Do	ath (Check only one)	No 1 □ Yes	21 70						
0 B	examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ☐ ER/Outpatier	Other	Home 5 Residence	6 ∏Other (Spa	cify)						
I.	27. Manger of Death 28a. Date of In	ury 28b. Time o	f 28c. Injury at	28d. Describe how in		ony)						
atio	1 Natural 5 Pending (Month, D	ay Year) Injury	Work? M 1 ☐ Yes 2 ☐ No									
Certification:	3 Suicide 6 Could not be 28e. Place of tr	njury - At home, farm, str	reet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,						
Sert	5 Building, 6	ic. (Specify)		Only of Town, Ste	110)							
sai (29a. Certifier 1 Certifying Physicien: To the bes	t of my knowledge, deat	h occurred at the time, date and place	e, and due to the cause	(s) and manner as	stated.						
Medicai	(Check only 2 Medicel Examiner: On the basis and manner s	oi examination and/or in tated.	vestigation, in my opinion, death occ	curred at the time, date a	na piace, and due	to the cause(s)						
Σ	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month	n, Day, Year)						
	MINA COUNT		D41168	2	~ mc 1	7 2005						
	30. Name and address of person who completed cause of	death (Item 23a) (Type,	1 1 1		1	CND						
	1 6-duft 1619	d Doc	stori Drive	Germ	antown	n 20874						
ate	2000	trar's Signature	Coarte			·						
rar	JUN 2 1 2005	Mercus L	Locales .									
2001												

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State

Registrar

			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygie	4000	20500
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Selmic Gentry	2. Date of Death Month	Day Year	3. Time of Death 2:24 A M
7	Examir		4a. Facility Name (If not institution, give street and number) Whive a sity of Many land Medical center Baltimere	h	4c. County of Dea	
	Funeral Director		5. Social Security Number 152-42-0014 6. Sex 1		9. Bir -51	thplace (State or Foreign ountry)
	show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the M or 28a-f	Director	10e. Street and Number 10f. Zip Code	10g.	. Citizen of What C	
	ns 23s	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (See Specify Cuban, Mexican, Puerl	Specify Yes or No-	14. Race - Ame	erican Indian,
980	ours after rai', or ite Exemire	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	to Rican, etc.)	Specify: E	te, etc. Black
21215-0036	"na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	rking	o. Kind of Business	/Industry
	filed withln Hygiene. ther than nt, the Mi	Com	12 Nurse Assistan	nt H	ialth Car	e/Nursing
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, I	To Be	Willie Yearce Marg	aret E	Burrel	
	s 1 and 2 should Health and Men tem 27 is marke other traumatic		Ralph Gentry Husband 9 Kittridge Ct. Ra	nduls-fou	ity or Town, State, .	Zip Code) 21133
nore	00-		20a. Method of Disposition 1	Date 200	Location - City or	Town, State
Baltimore,	permit. Pag Department Important: I any injury o once.		1. Signature of Funeral Service Licensee 22. Name and Abdresson Facility 22. Name and Abdresson Facility	ne funer	al Servi	03 M> 21133
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	JU 300 / (Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Crebral Edemá Due to (or as a consequence of):			10 HOURS
Ł	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate b. Brain Tumor Due to (or as a consequence of):			
abla	and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
8760,	be exician buria	dical Ex	resulting in death) Last Due to (or as a consequence of): d.			
. Box 68	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
P.0.	ires that the de signed by the a l be detached f	Phys	9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ords,	w requires been signe should be	ted by		1 ☐ Yes	./	robably 4 Unknown
		Completed		24a. Was an autopsy performed	7 death?	utopsy findings available completion of cause of
Vital	Physiclan: this certific ral director,	Be	examiner?	th (Check only one)	0 T0# (0	
o	> 0 0	on: To	27. Manner of Death 17 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	ome 5 Residence		сиу)
Division of	To the Hospital or Attending Ph. within 24 hours atter death. To the Euneral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify)	28f. Location (Street City or Town, St		ıral Route Number,
Ö	pital or ours afte leral Dir filled in	al Cert	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place			stated
	the Hos nin 24 h the Fur npletely	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	rred at the time, date	and place, and due	to the cause(s)
	To To cor	1	29b. Signature and title of certifier P16602		Date signed (Mont)	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Many land Medical Center 22 South Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Wirchan 54. B.H.	sky more Mo	21201
	s Sta Registr	tė ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		12 1 10	JUIN G I LUUJ RINGING KI			